

Cumbria LINK – Young People’s Social Prescribing Service Evaluation Report

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Changing childhoods. Changing lives.

Foreword

Barnardo's remains firmly committed to ensuring that every child has the support, safety, and opportunities they need to thrive. This independent evaluation of the LINK Service demonstrates how that commitment is being delivered in practice across Cumbria. The findings highlight a model of early help that is relational, timely, and deeply child-centred reflecting our priority to place children's voices and rights at the heart of all we do.

The LINK Service has become a trusted component of the local system, bridging gaps between primary care, schools, and community organisations and offering families support that is both compassionate and practical. Its integrated, collaborative approach reflects Barnardo's strategic ambition to reduce inequality, strengthen families, and work in partnership to achieve lasting change.

The evaluation also sets out clear areas for future investment, including strengthening workforce capacity, improving data and governance systems, and addressing rural access challenges. These priorities will be essential to ensuring the long-term sustainability of a service that is already delivering significant value for children, young people, and their families.

At Barnardo's, we are proud of the impact achieved so far and remain committed to working with our partners to build on this strong foundation.

Steve Oversby

Executive Director – Children's Services

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Evaluation Summary

About the LINK Service

- ⌚ Barnardo's holistic social prescribing service for children & young people (ages 5–19).
- ⌚ Co-designed with young people.
- ⌚ Operates across six Primary Care Networks in Cumbria.
- ⌚ The LINK service offers two pathways:
 - A coordination pathway, focused on relational support, system navigation, and onward connection
 - A one-to-one support pathway, offering 6–12 weeks of one-to-one, group work, and community connections.

Evaluation Approach

3-year independent evaluation by Edge Hill University

Methods:

Longitudinal interviews
Focus groups
Service data analysis

Interviews

15

Children and Young People

18

Parents

9

Parents - Coordination Only

9

Professional Referrers

17

Scoping Staff

9

Programme Board

"I literally feel like I was born again."

"Yeah, my goal from the start was to just get my spark back and that's exactly what I got."

"I feel like I'm still getting more confident."

Key Findings

Prevention & Early Intervention:

Timely support prevents escalation, reduces CAMHS referrals, and builds protective factors.

Positive Outcomes:

- Reduced anxiety and panic-type responses.
- Improved school attendance and participation.
- Calmer households and stronger family communication.
- Increased confidence, social participation, and future orientation.

Community Integration: LINK is embedded as a first port of call for schools and GPs, bridging gaps between primary care and CAMHS.

System Impact: Relieves pressure on GPs and specialist services, provides a trusted safety net, and promotes collaboration across sectors.

Enablers

Strong relationships and trust with CYP, parents, & referrers

Flexible, personalised, child-led model

Strong integration with schools, GPs, and community assets.

Barriers

Funding insecurity and workplace pressures

Variable awareness and communication gaps.

Geographic inequities in access.

Recommendations

- **Sustain and scale** the model through long-term funding and workforce stability.
- **Promote and communicate** LINK's role clearly across schools, GPs, and partners.
- **Integrate** with Family Hubs, ICS structures, and CAMHS pathways for joined-up care.
- **Invest** in workforce development – training, supervision, and wellbeing support.
- **Ensure equitable access** across rural and under-served areas.
- **Protect the ethos** – maintain relational quality and flexibility as LINK expands.
- **Strengthen data and reporting** to evidence ongoing impact and guide replication.

Executive Summary

The Barnardo's LINK service was established in Cumbria to address a critical gap for children and young people (CYP) experiencing social, emotional, and mental health difficulties that fall below specialist thresholds (e.g., Child and Adolescent Mental Health Services, CAMHS). Cumbria is a predominantly rural county in Northwest England with a dispersed population of approximately 500,000 across a large geographical area (approx. 2,600 square miles). Co-produced with young people, the LINK service provides a holistic offer centred on one-to-one support, group work, social prescribing (including nature-based), and system navigation (i.e., a coordination pathway). Delivered by trained LINK service workers, the service offers two key pathways: (1) a coordination-only pathway, in which practitioners complete an initial assessment, liaise with partner agencies, and connect families to the most appropriate source of help; and (2) a one-to-one therapeutic pathway that supports children and young people aged five to nineteen through a flexible, relationship-based approach. Workers combine emotional support, practical problem-solving, and asset mapping to connect children and families to local activities and services. The LINK service positions the child-worker relationship itself as a therapeutic mechanism, offering a safe, trusted space while building skills for resilience, and confidence. By working in homes, schools, GP practices, and community spaces, it reduces barriers to engagement and provides a bridge between multiple systems.

The evaluation conducted from 2022 to 2025 was commissioned as a learning partnership with Barnardo's to assess the service's impact, implementation, and sustainability of the LINK service model. A multi-methods design was used, incorporating a process and impact evaluation approach. Routinely collected survey data from 371 CYP were analysed to assess the effectiveness and cost-effectiveness of the service. Child Outcome rating Scale (CORS) data were available for one of the two support pathways of the service (one-to-one support pathway), as outcomes associated with the coordination pathway were not collected due to the nature of onward referral and delivery by external services. In addition to survey data, a total of 22 semi-structured interviews were conducted with CYP from 15 families, with a small number participating in follow-up conversations to capture change over time. Alongside this, 27 interviews were carried out with parents or caregivers. Nine interviews were conducted with professionals referring into the LINK service, providing insight into its positioning within wider systems. From a service delivery perspective, 17 scoping interviews were undertaken with LINK service workers across strategic and operational levels, complemented by nine interviews with LINK service board members. In addition to interviews, a logic model workshop was conducted to help outline the intended outcomes of the service and provide a framework against which evidence was interpreted. Data collection was concluded in June 2025 and so the evaluation only reflects the impact of the LINK service prior to this time.

The evaluation findings show that the LINK service delivered meaningful and clinically significant improvements in children and young people's (CYP) mental wellbeing (measured by CORS). Outcome data from 371 participants receiving the one-to-one support pathway, indicate an average improvement of 7.3 points (CORS), exceeding accepted thresholds for clinical significance and suggesting tangible gains in mental wellbeing. The cost-effectiveness analysis revealed an average cost of approximately £2,672 per outcome-assessed child, with an estimated cost of £368 per CORS point gained. When contextualised within the wider CYP mental health evidence base, these costs fall within, and in some cases exceed, expected costs for effective early-intervention models which achieve measurable clinical gain. In contrast, cheaper mental wellbeing focused interventions for CYP are often found to have limited or no effect on mental wellbeing outcomes. Overall, the analysis indicates that the LINK service achieves greater or equivalent outcome gains for similar investment, with added value arising from its integration across primary care, education, and community systems.

The evaluation findings highlight the added value of the LINK service. Families and professionals alike praised its timeliness, flexibility, and success in engaging children who might otherwise disengage from support (due to long waiting lists for specialist mental health support). The relational approach emerged as the service's greatest strength, with young people frequently reporting that they felt heard, safe, and able to express difficult emotions. Parents valued being listened to and supported, while General Practitioners (GPs) noted that the service reduced inappropriate referrals and eased pressures on primary care. Practical coping strategies promoted by LINK service workers were sustained beyond discharge and translated into improved functioning in school and family life. Perceived outcomes included greater confidence, and enhanced ability to manage anxiety. Commissioners emphasised that the LINK service filled a critical gap in a system under strain, offering timely early help to growing numbers of CYP experiencing stress and mild anxiety.

At the service level, LINK demonstrated notable flexibility in adapting to the evolving needs of service users, underpinned by a framework of strong governance. LINK service workers frequently highlighted the value of specialist supervision and ongoing professional development. This was a result of Barnardo's transformational leadership approach that prioritised staff development, enhancing both professional confidence and service quality (Howarth et al, 2025). Yet, alongside these strengths, the evaluation highlighted several challenges that reflect wider systemic issues across the social care landscape. For example, short-term funding arrangements and the potential escalation of caseloads (mirrored nationally) put pressure on staff wellbeing and retention, threatening the sustainability of the service model (Kimberlee et al, 2022). Geographic disparities further compounded these pressures, with families in rural areas often struggling to access the group-based provision offered by the service.

The evaluation highlighted several priorities to strengthen and sustain the quality of the service. Central to this is the protection of relational quality, that is, the depth, consistency, and authenticity of the relationships between LINK service workers, children, young people, and families. This aligns with the principles of relationship-based practice, conceptualised as a ‘holding relationship’ that enables trust, empathy, and emotional containment as precursors to therapeutic change (Ferguson et al, 2020). Maintaining relational quality depends on manageable caseloads, sufficient time for reflective supervision, and organisational structures that value emotional as well as procedural work. Clearer referral pathways are also required, supported by comprehensive guidance for referrers and more accessible communication materials to help families understand what to expect from the service.

Operational efficiency emerged as another key area for development. Streamlining administrative processes particularly through refining electronic patient record systems (e.g., IAPTUS) and standardising documentation (e.g., data entry templates for system input), would reduce burden on practitioners and free up time for direct work with families. Alongside this, workforce development should be broadened to encompass trauma-informed practice, and systems thinking, thereby equipping staff with the skills needed for complex, multi-agency environments.

Looking ahead, medium-term priorities include addressing rural inequities, refining triage processes, and enhancing the service’s visibility among partners and stakeholders. In the longer term, sustainability will depend on securing multi-year funding, embedding the LINK service within Family Hubs and local health systems, and undertaking economic evaluations to quantify the return on investment.

Key findings from the evaluation highlight:

- **Impact:** the LINK service delivered improvements in children and young people’s mental wellbeing. Its relational, child-centred approach, combined with timely access, helped young people better manage mental health difficulties.
- **Implementation:** The LINK service was supported by strong governance, specialist supervision, and a flexible model that adapted to the needs of children and young people. Stakeholders frequently reported that the LINK service provided timely, accessible early help and effectively engaged CYP who might otherwise disengage from support.
- **Sustainability:** the LINK services adaptability, workforce development, and integration across primary care and community systems acted as key enablers of sustainability. However, short-term funding, and rural access challenges, continue to pose risks to the long-term stability of the model.

Key lessons from the evaluation emphasised:

- The importance of protecting the LINK service relational approach, flexibility, and bridging role across systems.
- Small caseloads, continuity with a named worker, and protected supervision were identified as essential to sustaining a high-quality service.
- Flexibility in delivery and co-produced coping strategies were critical for engagement and lasting benefit.
- Continued strong governance and the need to reinforce credibility with more robust data systems to evidence impact.

The learning partnership approach taken by the evaluation supported the ongoing translation of findings to improve practice, allowing the LINK service to make real-time adaptations from the above lessons. Consequently, many of the recommendations have already been implemented (e.g., protected caseloads, streamlining admin, standardising documentation and enhancing the triage processes) to improve the effectiveness and efficiency of the service.

In conclusion, this evaluation highlights how a relational, community-based model of early intervention benefits children, young people, and families by improving wellbeing, confidence, and resilience. It also provides practical learning for professionals and commissioners on how social prescribing can be embedded within local systems to strengthen early help, reduce pressure on statutory services, and inform future policy and commissioning decisions. Its future, however, will depend on consolidating these strengths, addressing challenges around equity, and securing the resources necessary to sustain its impact.

Introduction

This report presents the findings from Edge Hill University's three-year independent evaluation of the Barnardo's LINK service (2022 to 2025), an early intervention model as part of a social prescribing (SP) supporting children and young people (CYP) aged 5 to 19 years. The report is structured to provide a comprehensive account of the service's development, delivery, and outcomes. It begins by situating the LINK service within the national and local policy context before outlining the evaluation design and methods. The findings are then organised around three overarching questions: (1) the impact of the LINK service and how it is achieved, (2) the extent to which the service has been implemented as intended, and (3) the factors influencing its sustainability. The report concludes with key learning points and recommendations for future service development and policy planning.

Contextualising the Policy Landscape

The United Kingdom (UK) Government's Ten-Year Health Plan for England: 'Fit for the Future' (2025) sets out an ambitious, transformative vision for the health and care sector. The plan aims to future-proof the National Health Service (NHS) through three shifts: delivering care closer to home, prioritising prevention, and expanding digital integration. A central tenet of the plan is to co-create localised models of care that are influenced by community priorities as opposed to current service boundaries (UK Government, 2025). It is envisaged that this will enable a more personalised and equitable health service through the implementation of a neighbourhood health service, which includes multi-disciplinary teams working within neighbourhood health centres. These centres will help integrate genomic and digital technology such as the NHS App and address systemic challenges associated with integration to reduce siloed working and provide a service that is fair for all. Significantly, there is a commitment to empowering communities through co-design of services to tackle systemic challenges and promote innovation in deprived areas, strengthening relationships across the health, social care, and voluntary sectors (Care Quality Commission, 2025). Arguably, this shift will require strong collaborations with the voluntary and community sector organisations (VCSEs) to influence transformation and embed strengths-based working at the heart of service redesign.

Within the context of children, young people, and families, the shift toward a more community-centred model of care offers a powerful opportunity to foster deeper integration across education, social care, and family support services (Callendar, 2025). This will be primarily realised through the neighbourhood health service and the introduction of Family Hubs. Mental health (MH) support services for CYP have been a priority, and the plan details the expansion of mental health support through MH Support teams in colleges and schools (NHS England, 2025). This will be further supported by the creation of Young Futures Hubs which will use integrated approaches

that are tailored for CYP and families to ensure that there are timely and appropriate personalised interventions. Ultimately, the plan lays the foundation for a strengths-based, community-led approach that seeks to dismantle siloed working, promote collaboration, and empower communities to co-create solutions that improve wellbeing.

Within this emerging community-led model of care, social prescribing has become a key vehicle for translating these policy ambitions into practice, particularly for CYP, where integration across health, education, and community systems is vital to improving wellbeing and access to early support.

Contextualising the Landscape of CYP Social Prescribing

According to the National Academy for Social Prescribing (NASP), CYP social prescribing is an emerging approach that connects young people with non-clinical support and community-based activities to improve their health and wellbeing. This model recognises that many of the challenges affecting CYP such as mental health issues, social isolation, and physical inactivity are influenced by social, economic, and environmental factors (Gautam et al, 2023). SP offers a way to address these root causes by linking young people to activities and services that matter to them, such as sports, creative arts, volunteering, or support with education and employment. This approach closely aligns with the government's National Youth Strategy, which emphasises addressing the social determinants of health and prioritises prevention, early intervention, and access to enriching activities as foundational to improving youth outcomes. Although SP was initially focused on adults, the number of services tailored to CYP is now increasing, reflecting demand for asset-based approaches amid long statutory waits.

Initiatives such as Street Games, Manchester Youth Zone, and Barnardo's LINK service highlight the growing value of SP for CYP. The NASP's 'Connected to Thrive' report (2025) calls for national expansion and dedicated LINK service workers across schools, GP practices, and community organisations to help young people navigate complex challenges, build confidence, and access meaningful opportunities, such as the LINK service that promote wellbeing. The rise in mental health needs among CYP, coupled with long waiting times for statutory support, underscores the importance of such asset-based approaches. SP empowers young people by giving them a voice in their care, fostering ambition, and reducing health inequalities, particularly in underserved communities.

Growing evidence highlights the benefits of SP services for CYP. Engagement in activities such as the arts, music, nature-based experiences, and physical exercise has been shown to improve mental wellbeing, alleviate loneliness, and enhance cognitive functioning (Viola et al, 2023). According to the National Academy for Social Prescribing (NASP), SP interventions are particularly effective for individuals aged 17

and above, contributing to enhanced personal wellbeing and reduced social isolation. Similarly, emerging evaluations demonstrate SP's positive impact on mental health, Husk and Berry (2024), for example, found that SP can enhance psychological health, mitigate loneliness, and offer a favourable return on investment. Together, these findings underscore the potential of SP as a holistic, non-clinical system to promoting psychological resilience and social connectedness among CYP. However, challenges remain, particularly the need to ensure equitable access, secure sustainable funding for community-based services, and actively involve CYP in the co-design of programmes. These challenges mirror those identified in the national youth strategy, which highlights variability in local provision, workforce capacity, and the need for meaningful co-production rather than consultation alone.

The role of LINK service workers is central to the effective delivery of a SP service for CYP. Evidence from the National Academy for Social Prescribing and Feather et al. (2025) indicates that LINK service workers can facilitate reductions in anxiety, improve school engagement, and support positive transitions into further education or employment. Feather et al. (2025) further highlight the potential of socially prescribed services to enhance mental health and wellbeing outcomes, while Farinna et al. (2024) emphasise the critical function of LINK service workers within children's services. These professionals act as connectors, taking time to understand the unique needs, interests, and circumstances of CYP, and linking them to appropriate community resources, activities, and support services. Their empathetic, person-centred approach is instrumental in fostering trust and engagement which are particularly vital for CYP experiencing mental health difficulties, social isolation, or complex social challenges.

As mental health needs among CYP continue to rise (exacerbated by the pandemic and cost-of-living crisis) SP offers a timely, holistic, and person-centred solution. It complements clinical care by addressing the social determinants of health and creating pathways to resilience, belonging, and purpose. This integrated offer reflects the youth strategy's call for better coordination between statutory services and community-based provision, moving away from fragmented responses toward whole-system approaches. However, despite its potential, engagement with SP remains limited among younger cohorts. Notable gaps in the evidence base include the absence of long-term outcome data and the lack of standardised evaluation frameworks, which are critical for assessing impact and informing future practice.

Against this backdrop, the EHU team collaborated with the LINK team to co-develop a series of learning questions, designed to guide the learning partnership and inform the subsequent evaluation. These questions were carefully co-designed to ensure the collection of meaningful data that would illuminate the impact of the LINK service. In addition to assessing outcomes, the partnership aimed to explore the underlying mechanisms of the LINK service, thereby enabling a deeper understanding of its influence across multiple levels and sectors.

Understanding the LINK service's impact requires situating it within the wider context of CYP mental health in the UK, where rising distress and inequality shape both need and provision.

Children and Young People's Mental Health in the UK: A Policy and Practice Overview

The health challenges facing CYP in the UK are increasingly complex and deeply interconnected. Among the most urgent concerns is the sharp rise in mental health conditions, including anxiety, depression, self-harm, and eating disorders (Borg et al, 2025). These issues are often compounded by social isolation, delayed access to early intervention, and overstretched support services. The Health Foundation (2025) highlights that this growing mental health crisis affects not only the individual child or young person, but also their families and the wider society.

Recent research by Youth Futures (2025) examined the drivers of declining mental health among young people aged 14 to 24 years. It identified several contributing factors, including worsening sleep quality, economic precarity (particularly around housing and employment), reductions in youth services, increased social media and smartphone use, and rising levels of discrimination and environmental anxiety. The Youth Futures research confirms that this decline reflects a genuine deterioration in mental wellbeing rather than increased awareness or reporting. It also underscores the urgent need to prioritise mental health services for CYP through preventative strategies that integrate health, education, employment, and community sectors. A coordinated, cross-sector approach is essential to address the complex factors shaping young people's wellbeing and to develop a comprehensive youth strategy that fosters resilience, strengthens connections with trusted adults and community networks, and ensures that no young person is left behind (Youth Futures, 2025).

Research conducted by the Health Foundation (2025) reported that family circumstances, particularly household poverty, and financial instability, remain among the most significant drivers of poor mental health outcomes in CYP. The Health Foundation reveals that more than half of CYP in the UK are exposed to either family poverty or poor parental mental health during childhood, with this dual exposure having profound and lasting effects on their emotional wellbeing. Notably, around 40% of socio-emotional problems in adolescence can be attributed to the co-occurrence of poverty and poor parental mental health. These findings are echoed in the 'A Dual Crisis report' by Save the Children UK, Centre for Mental Health, and the Children and Young People's Mental Health Coalition (2024), which highlights that children in the poorest households are four times more likely to experience serious mental health difficulties by the age of 11 compared to their wealthier peers. The report also notes that 4.3 million children in the UK are currently living in poverty, with rates disproportionately higher among families from diverse ethnic communities, lone parent

households, and those with disabled members. The psychological distress experienced by parents in these circumstances, often exacerbated by punitive welfare systems and housing insecurity, has a direct and detrimental impact on children's mental health. This highlights the intergenerational nature of mental health vulnerability and the need for holistic, family-centred interventions.

The long-term effects of deprivation are evident in both physical and mental health outcomes. Goesis et al. (2015) found that children in the lowest income quintile were twice as likely to be obese at age 5, rising to three times more likely by age 11. Griffiths et al. (2021) reported that this gap has doubled over the past two decades, underscoring the enduring impact of socioeconomic disadvantage on child health. Recent studies also highlight a clear link between childhood obesity and mental health difficulties. A UK cohort study by Putra et al. (2025) found that children who developed or maintained obesity between ages 7 and 17 years were significantly more likely to experience internalising symptoms such as anxiety and depression, as well as externalising behaviours like aggression and impulsivity. Children who reduced obesity during adolescence showed no increased risk of mental health problems, suggesting that early intervention can mitigate long-term psychological harm. Collectively, this evidence emphasises the need to address poverty and the wider social determinants of health as part of any strategy to improve CYP wellbeing. It highlights the complex interplay between physical and mental health in the context of deprivation: children living in poverty face poor nutrition, limited access to physical activity, and chronic stressors that heighten both obesity and mental health risks. Tackling these challenges requires a holistic approach that addresses the root causes of inequality and promotes healthy lifestyles. Without this, efforts to expand mental health services and early intervention will have limited effect.

Recent policy developments demonstrate growing recognition of the need for integrated and preventative approaches to address the UK's CYP mental health crisis. The Mental Health Bill 2025, which modernises the Mental Health Act 1983, represents a major step forward in safeguarding the rights and dignity of young people. It introduces reforms to reduce unnecessary detentions, improve inter-agency coordination, and strengthen protections for those in inappropriate settings. The Bill also establishes a decision-making test for under-16s and a statutory right to advocacy, ensuring that young people are actively involved in their care.

Complementing this, the NHS *Fit for the Future* prioritises prevention, community-based care, and digital innovation, with a strong focus on CYP mental health. Key commitments include the national rollout of Mental Health Support Teams (MHSTs) in schools and colleges by 2029–30 and the creation of *Young Futures Hubs*: open access, youth-led centres providing integrated support for mental health, education, housing, and wellbeing. Co-created with young people, these hubs embody a shift toward responsive, community-rooted models of care (Hayes et al, 2023; Grice-Jackson et al, 2025; Youth Futures, 2025). Third sector organisations such as Barnardo's are central to this transformation. Through partnerships with health

systems, they address wider determinants of health, poverty, housing, and social exclusion, using asset-based approaches like social prescribing and family hubs. Together, these developments signal a shift toward a more holistic, preventative, and inclusive mental health system, one that acknowledges the complex realities facing CYP and seeks to intervene early, collaboratively, and compassionately. It is within this shifting national landscape that Barnardo's LINK service has evolved, providing a tangible example of how early intervention and social prescribing principles can be embedded within community and primary care systems to meet the complex needs of children and families.

The Evaluation of the LINK Service: Aligning Early Intervention and Social Prescribing with National Policy and Future Planning

Barnardo's (2023) report (*The Missing Link*) presents SP for CYP as an innovative and increasingly vital approach to addressing the non-clinical determinants of health. This approach reflects the priorities outlined in the NHS *Fit for the Future* Ten-Year Plan (2025), which emphasises prevention, integration, and community-based models of care, as well as the Government's wider commitments through *Family Hubs* and *Young Futures Hubs*. By facilitating access to community-based activities and support services, SP recognises the multifaceted nature of wellbeing and the limitations of conventional clinical interventions in meeting the complex needs of CYP. The LINK service directly responds to these policy ambitions by embedding holistic, relationship based early intervention as part of a SP within primary care and community systems, bridging health, education, and social care. In doing so, it addresses key priorities in national planning, reducing pressure on statutory services, promoting early help, and supporting equitable, localised care.

In response to escalating demand and long waiting times for statutory services, Barnardo's developed targeted initiatives such as the Cumbria LINK service. The LINK service exemplifies how services can be embedded within the SP system and primary care to deliver integrated, community-oriented support that addresses both the mental and physical health needs of CYP. Working in partnership with schools, GP practices, and community organisations, LINK service workers encourage participation in physical and social activities such as youth groups, outdoor programmes, and creative workshops as part of a SP. This reconnects CYP who may otherwise be socially isolated, often spending long periods online, to real-world environments that foster belonging, routine, and confidence. Evaluation findings demonstrate tangible impact, including improvements in anxiety, and greater engagement in education and social life. Young people have described the service as "life-changing," reflecting how its relational, community-based model meets the complex and interconnected needs of children and families in Cumbria.

Despite its growing recognition, the literature identifies several persistent challenges in scaling SP services for CYP. These include the need for stronger integration with statutory services such as CAMHS and educational institutions, as well as consistent training, supervision, and support for service workers to ensure effective delivery. Sustainable funding for community-based activities also remains a critical concern, particularly amid rising demand and stretched public resources. Turk et al's (2024) meta-ethnography provides further insight into the systemic factors shaping the effectiveness of link service workers, highlighting how success depends on role clarity, the availability of community resources, and institutional support. Without sufficient infrastructure and strategic investment, the study warns, the sustainability of SP and its ability to reduce health inequalities may be compromised. Alongside these challenges, emerging evidence demonstrates the positive impact of SP for young people, particularly those aged over 17 years, on personal and mental wellbeing. There is also preliminary evidence of a favourable return on investment (Hayes et al., 2023), suggesting that, with adequate infrastructure, SP could deliver both social and economic value.

Emerging policy briefings, such as those from the Social Prescribing Youth Network (SPYN) and University College London's Social Biobehavioural Research Group, emphasise the need for a national strategy to embed and sustain youth SP. Key recommendations include designated funding streams, improved data collection, and co-designed models that reflect local contexts and youth voices. As the field continues to evolve, there is a clear opportunity to build a robust evidence base that supports the wider integration of SP within health, social care, and education systems. SP offers a promising pathway to empower young people, reduce health inequalities, and deliver early intervention in a way that is responsive, inclusive, and rooted in community.

The LINK Service

The LINK service is a joint socially prescribed service led by Barnardo's in partnership with Primary Care Networks in Cumbria for CYP aged 5 to 19 years. It was codesigned with local school pupils, who helped to shape recruitment, branding, and priorities for delivery. The LINK service is deliberately positioned as a non-medical, holistic response to the everyday pressures that erode wellbeing, anxiety, low mood, loneliness, school worries, and relationship difficulties with peers or family, while also attending to the wider determinants (including rurality, transport and access barriers, poor physical health, elevated rates of suicide and teenage pregnancy). Referrals are intentionally broad with GPs (and other health professionals), schools, youth workers, and any other professional able to refer into the programme.



Figure 1. CSSO model (adapted by Barnardo's from Stewart, 2014)

The LINK model is unique as it is grounded in the CSSO framework which focuses on evidence-informed principles of child and youth centred practice (See figure 1 adapted from Stewart, 2014). The model is not a specific social prescribing framework but adopts a child-directed approach, placing the young person in the driving seat and using the therapeutic relationship itself as a key tool for change. The work is also system-focused, recognising that sustainable improvement depends on strengthening the relational health of the child's wider environment, including families, schools, and community networks. A strengths-based ethos underpins all practice, balancing an understanding of difficulties with an emphasis on capacity, potential, and "what's right" with each young person. Finally, the model is outcome-informed, encouraging regular reflection and feedback from children and families to ensure that support remains responsive, effective, and meaningful (Stewart, 2014).

Journey Structure

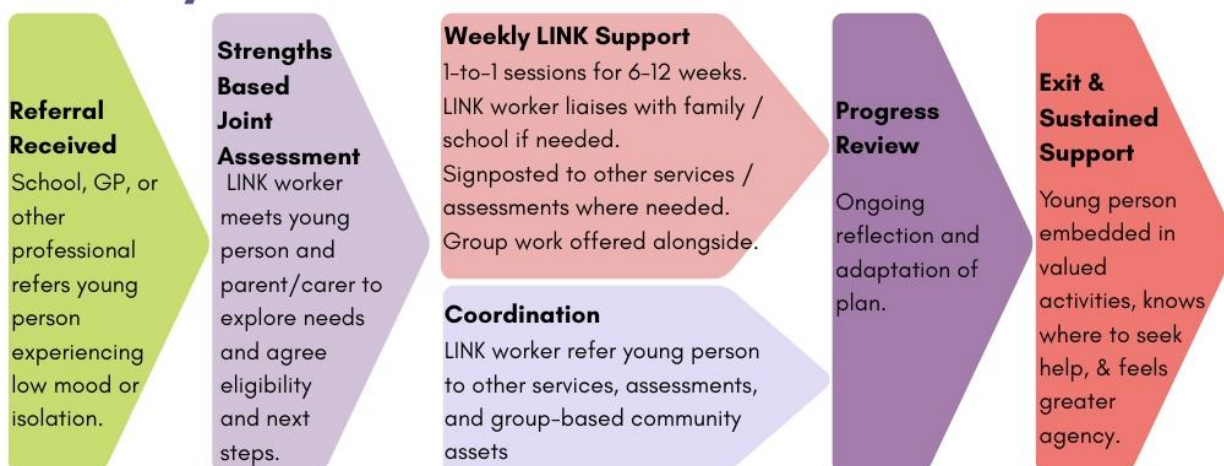


Figure 2. Journey structure

Access criteria into the LINK service model are broad, with the programme designed as a low-level wellbeing offer for CYP experiencing mild to moderate psychosocial difficulties (although they do adopt a ‘no closed door’ policy). While the service does not operate with strict access criteria, LINK service workers use an informal decision-making system during initial assessment to determine whether a young person is suitable for short-term support or requires referral to higher-tier mental health services (specialised services such as trauma services). Young people presenting with self-harm, suicide plans, or more severe and complex mental health needs are not accepted into the programme and are instead signposted or connected to specialist provision.

Operationally, the LINK service offers two main pathways in which CYP undergo an assessment to determine which one is most appropriate (see figure 2). The first pathway is a short-term (6 to 12 weeks), focused intervention for CYP who would benefit from structured one-to-one work (see figure 3). The second is a coordination-only pathway, where the LINK service worker connects the young person and their family with other services that are a better fit for their needs. Workers signpost or connect families to a broad range of statutory and voluntary services. These include the 0-19 Child and Family Support Services, MyTime (getting help service/ support), the local authority and specialist charities supporting children affected by domestic or sexual abuse. LINK service workers also refer to autism and disability services such as Owl Blue and Springboard, and to CAMHS where higher-tier clinical input is required. In cases involving safety or risk, families may be supported to access organisations such as SafetyNet. This diverse network of referral options helps ensure that CYP with more complex or higher-risk needs receive timely access to the most appropriate support. For both pathways, the process begins with an initial assessment

of need and a shared formulation of goals. LINK service workers use evidence-informed assessment tools to explore presenting worries and contextual stressors, agree priorities with the young person and their caregivers, and plan next steps. In the focused intervention pathway, this leads to a brief programme of care (typically 6 to 12 weeks, often framed as up to 10 sessions) delivered by specialist LINK service workers.

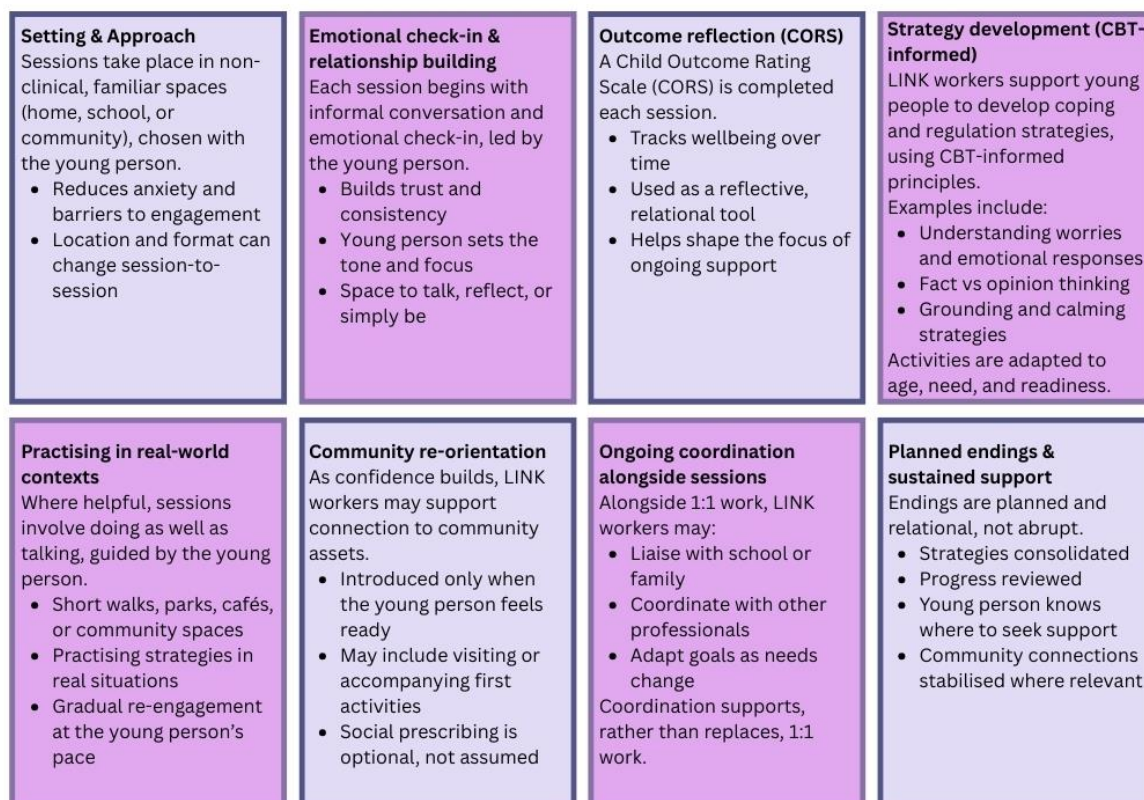


Figure 3. The 1:1 pathway in practice

A key component of the service is the LINK service workers, who work directly with CYP to address a range of issues. LINK service workers come from a range of professional and lived-experience backgrounds, with a shared focus on supporting children and young people. Although there are no formal qualification requirements, LINK service workers are recruited based on prior experience with CYP and their ability to build safe, trusting relationships. To ensure a consistent standard of practice, all LINK service workers complete a core training package covering trauma-informed approaches, and safeguarding etc. This diverse range of training is supplemented by ongoing supervision and reflective practice, equipping workers to deliver personalised, non-clinical support.

The relationship between the LINK service worker and CYP is treated as an active mechanism of change: young people are offered a reliably safe, trusting space in which they are listened to, positively challenged, and supported to reflect on what is

happening in their lives. Progress is reviewed iteratively against the young person's goals so that the work can pivot as needs evolve. Social prescribing and green social prescribing are then used to translate this formulation into action. LINK service workers map local assets connecting each young person to wellbeing-boosting opportunities in their own community. The menu is intentionally varied to offer genuine choice: art therapy; sport and physical activity; resilience and mindfulness; talking therapy (based on principles of CBT) peer-led groups; skills workshops; and informal drop-in wellbeing groups hosted in community venues. Alongside this, the LINK service attends to common presenting domains, including confidence and self-esteem, social isolation, peer difficulties, stress and mild anxiety, school-related worries, loneliness and sadness, resilience building and future goal setting, worry management, and family relationships.

Group work, volunteers, and peer mentoring extend the reach of the one-to-one offer and lay foundations for longer-term sustainability. The service invests in system-level capacity so that the wider ecology becomes more youth-friendly over time. This includes training and awareness sessions (including a focus on the CSSO Framework) for education and community partners, and a suicide-bereavement group for children. The LINK service's equalities focus runs through delivery: staff prioritise relationships with grassroots organisations led by and for young people who are minoritised.

Clinical governance and risk are managed through strong pathway integration rather than in isolation. The LINK service is connected to Barnardo's programmes such as Mental Health Support Teams (MHST) and MyTime, and there is close working with CAMHS (an NHS service providing assessment and treatment for CYP with more severe mental health needs) to ensure that young people are stepped up quickly when risks escalate or needs exceed the scope of SP (including green social prescribing) and stepped down to community support when specialist input is no longer required.

Changes and Adaptations to the LINK Service Over Time

Since its launch, the Barnardo's LINK service has undergone continual adaptation, evolving from a rapid, needs-responsive pilot into a more structured, system embedded intervention while maintaining flexibility and responsiveness. Figure 4 illustrates the four key phases of this development, highlighting how the LINK service has matured operationally and strategically over time.

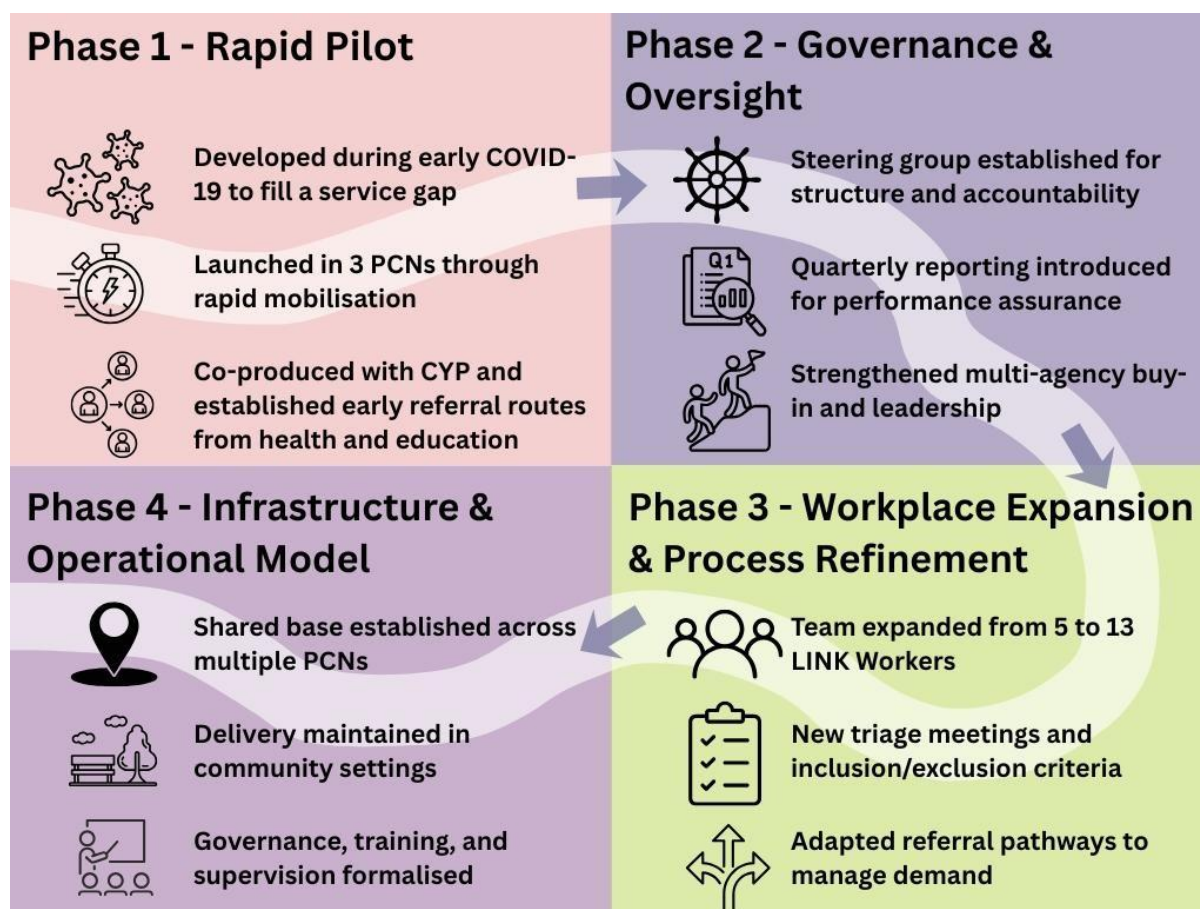


Figure 4. The Changes / Adaptations of the LINK Service

The LINK service was implemented in 2020, when primary care clinicians identified a pressing and unmet need for CYP presenting with social and emotional difficulties below clinical thresholds. Responding to this gap, Barnardo's rapidly mobilised funding to develop a bespoke children's social prescribing offer, initially within three Primary Care Networks (PCNs). Early implementation was notable for its speed and multi-agency orientation, establishing a range of referral routes and co-producing the service with CYP (which included focus groups and participatory methods). This foundation marked the first pivot point, a rapid mobilisation to fill a service gap with initial parameters shaped through local leadership and early stakeholder engagement.

The second phase focused on strengthening governance and oversight. Stakeholders described the creation of a steering group as critical in moving the LINK service from a start-up phase to an embedded, credible service, with quarterly reporting providing both narrative depth and performance assurance. This formalised oversight enabled the programme to consolidate multi-agency buy-in and sustain growth.

The third phase involved workforce expansion and process refinement. The team grew from five to thirteen LINK service workers, requiring coordinated recruitment,

induction, and training. LINK service workers developed weekly allocation meetings to triage referrals dynamically, balancing the need for prompt responses to urgent cases. Access pathways were also adapted, with temporary pauses on school referrals to manage demand and the introduction of clearer inclusion and exclusion criteria to minimise inappropriate referrals while maintaining the service's coordination role.

The most recent phase (phase 4) involved strengthening infrastructure and operations. Barnardo's established a shared base to support staff across multiple PCNs while maintaining delivery in community settings such as homes, schools, and parks, reflecting young people's preferences. Barnardo's had overall responsibility of governance, training, and supervision of LINK service staff, taking direct responsibility for professional oversight. In addition, a revised management structure was implemented to enable senior practitioners to undertake enhanced functions, including case management, monitoring, and triage, strengthening oversight and responsiveness. Alongside these internal developments, the service expanded its wider engagement work, extending its influence beyond core referrals. This included active participation in school assemblies, citizenship days, PRIDE events, and other community-based activities, as well as delivering fun days and coordinated summer and winter offers. Collectively, these initiatives were designed to promote the service, increase visibility, and improve reach across multiple geographic areas.

In summary, the evolution of the Barnardo's LINK service over its first three years can be understood as a sequence of adaptive shifts: from an emergency-initiated, rapidly deployed pilot, to an established, multi-PCN service with formal governance; through a period of rapid workforce expansion and process consolidation; and towards an infrastructure and operational model that balances physical centralisation with decentralised, community-based delivery. This progression demonstrates both responsiveness to external conditions and a deliberate embedding of governance, training, and systems integration, positioning the LINK service as a distinctive, sustainable model for children's social prescribing in a complex service landscape.

Evaluation Design and Methods

Evaluation Approach

In line with the evaluation plan and learning questions, the evaluation team assessed the impact, implementation, and sustainability of the LINK service across three levels: individual (CYP and their families), community, and service.

From 2022 to 2025, the evaluation team undertook a comprehensive programme evaluation which included several timepoints of data collection and analysis. A key early activity was a logic model workshop involving strategic staff from Barnardo's and partner organisations. This session was instrumental in articulating the rationale for the LINK service and clarifying intended outcomes (see figure 5 for Logic Model).

To complement qualitative evaluation inquiry, the evaluation accessed routinely collected service data from IAPTUS, the electronic health record platform used across Barnardo's mental health and trauma services. These data supported assessment of service reach and outcomes at the individual level.

Learning Partnership

As the commissioned learning partner, Edge Hill University (EHU) worked closely with Barnardo's to generate a robust understanding of the evidence base, operational dynamics, and key lessons emerging from the delivery of the LINK service. Central to this partnership has been a commitment to continuous reflection and iterative learning. EHU's role as a 'critical friend' has allowed the research team to offer constructive challenge, facilitate reflexive dialogue, and support the LINK service workers in interrogating their own practice. This process has enabled the identification of strengths, emerging challenges, and contextual factors influencing programme outcomes. Through systematic analysis and ongoing feedback loops, EHU has contributed to deepening the LINK service worker's insight into what aspects of the service are functioning effectively, where improvements may be needed, and the underlying reasons for these patterns. By combining academic rigour with an applied, practitioner-focused perspective, the partnership has not only enhanced service delivery in real time, but also generated learning that can inform future practice, both within the LINK service and in wider service contexts.

Programme Logic Model

As part of the learning partnership, EHU worked with the Barnardo's LINK team to undertake a logic model workshop. This was to clarify LINK service goals and outcomes, map referral pathways to impact, strengthen strategic planning and help to determine the shape of the wider evaluation (Figure 5).

The logic model workshop was conducted in the first year of the evaluation and provided a narrative that describes how activities generate and influence impact. Through the workshop, the evaluation team were able to identify and discuss the range of inputs required to support effective service delivery of the LINK service. These inputs include the initial assessment and ongoing reviews, a planned programme of one-to-one work with a LINK service worker, structured opportunities to socialise with peers, peer-mentor training and delivery, co-production of the project itself, and co-production that influences the design of other local services. Through these activities, the mechanisms of change identified included:

- feeling safe and able to trust LINK service workers, feeling listened to, and learning to respond productively to challenge.
- developing the ability to reflect on and address issues affecting quality of life and feeling empowered to create change.

As these mechanisms are achieved, intermediate outcomes emerge: young people feel less isolated; relationships with peers, family members, and statutory services improve; self-awareness about what affects their emotional wellbeing increases; confidence and judgement strengthen so they make better decisions about their health; resilience grows so that they can respond to life's challenges; literacy about where to go for help improves; and positive engagement with services outside the project increases. The ultimate impact is that young people experience and maintain improved emotional wellbeing, with gains sustained by the community links and skills they have developed.

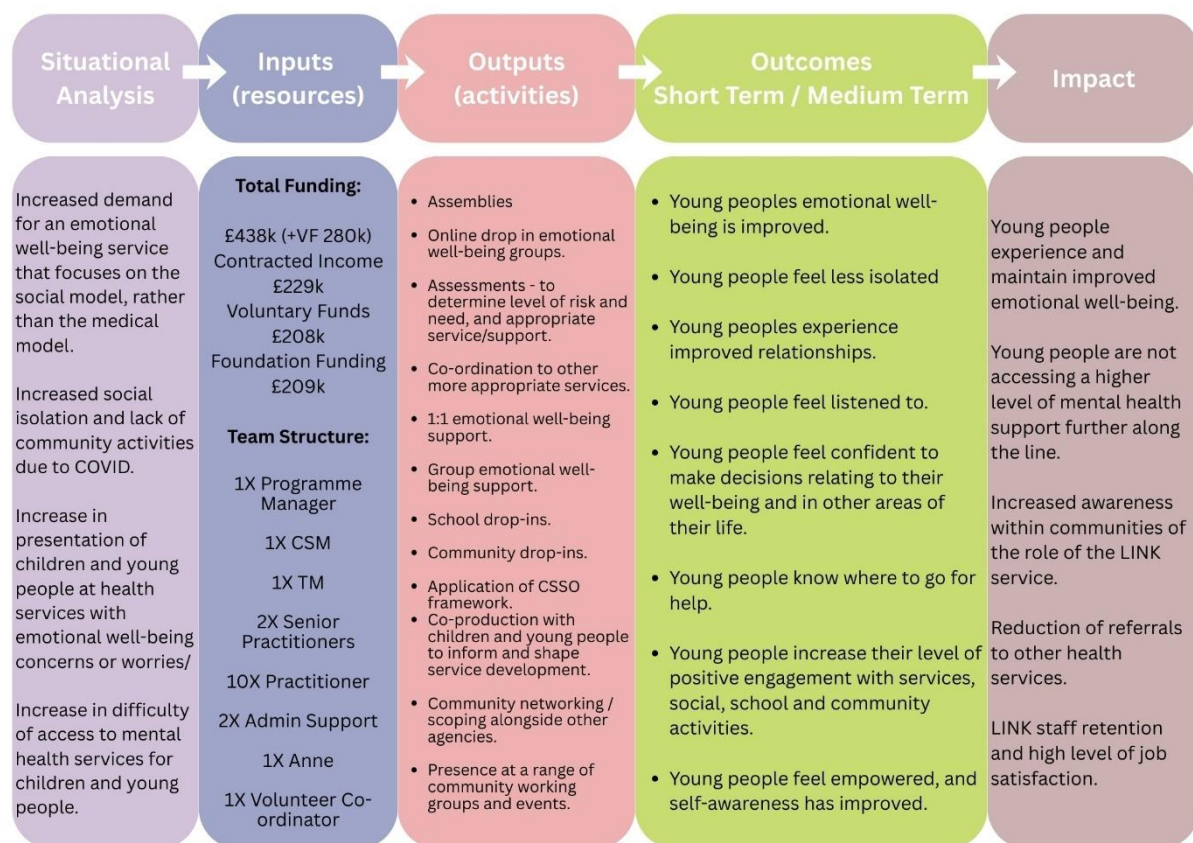


Figure 5. The LINK Service Logic Model

In practice, a typical journey might involve a school or GP referral for a young person experiencing low mood and isolation (see Figure 2, the journey structure, for an illustration). After a joint assessment, the young person either gets referred to another service or they meet their LINK service worker weekly over six to twelve weeks. During which time they may try out a creative group in a nearby community hall, or the LINK service worker may connect them with a nature rambling group for example. The LINK service worker teaches and shares simple strategies for anxiety, helps the family solve transport issues, liaises with school on a supportive timetable, and, where relevant, consults with the mental health support team or CAMHS via triage to ensure risks are safely managed. The LINK service worker writes progress reviews which track change and the plan is adapted as needed. On leaving the LINK service, the young person can select from a menu of activities they value which can support them, and they know where to seek help. Ultimately, the support that the LINK service has provided enables the young person to have a clearer sense of agency in their own life and local partners are more connected around the young person's needs.

Seen as a whole, the LINK service is a multi-layered community intervention rather than a single programme. It couples a time-limited, relationship-centred programme of care with purposeful SP and system-facing work. By aligning activities to clearly

articulated mechanisms of change and by integrating with established pathways, it adapts community resources into protective factors, reduces isolation, and strengthens the conditions in which CYP in Cumbria can maintain improved emotional wellbeing.



Photo 1. Creative outputs of CYP group work

Evaluation Questions

At the onset of the evaluation there were three key evaluation questions which encompassed some sub-questions (see figure 6):

1. What **impact** is the LINK service creating and how?
 - a) What impact is the LINK service having on CYPs wellbeing and quality of life?
 - b) What impact is the LINK service having for families and why?
 - c) What is the impact of the LINK service at a community and service level?
 - d) What is the economic impact on services?
2. To what extent is the LINK service being **implemented** in line with plans and stakeholder expectations?
 - a) How do CYP and families describe their experiences of the LINK service?
 - b) To what extent does the LINK service work across all PCNs?
 - c) What is the perceived level of integration?
3. What enablers and barriers affect the **sustainability** of SP and how?
 - a) How sustainable are the changes experienced by CYP and families?
 - b) What enabling factors are needed for a new SP service to be successful?
 - c) How can the prospective benefits of the LINK service be integrated into Business as Usual?

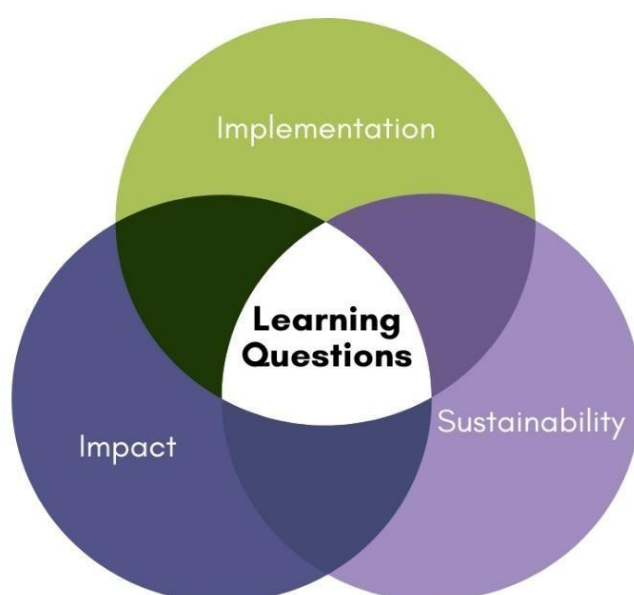


Figure 6. Learning questions

Data Collection and Recruitment

The evaluation team employed the Learning Partnership Questions as a framework to guide the evaluation of the LINK service. This approach enabled the collection of diverse perspectives (from CYP, LINK service workers, and commissioners) thereby generating a rich, multi-layered understanding of the service's impact from a strategic, high-level viewpoint. Hence, the evaluation collected a range of data to capture the experiences and perspectives of CYP, parents and carers, staff, professional referrers, and strategic stakeholders involved in the LINK service. Data collection began in 2022 and combined longitudinal qualitative interviews, focus groups, and analysis of routinely collected service data. Data collection was concluded in June 2025 and therefore the evaluation only reflects on the LINK service prior to this time.

To enable the collection of data over the duration of the CYP journey with the LINK service, the evaluation team worked with the LINK service workers and CYP and their families to facilitate longitudinal, semi-structured interviews at three timepoints: baseline (before intervention), midpoint (approx. 6-8 weeks follow up), and final contact or discharge (1-2 weeks post intervention). While some participants were unable to complete interviews at all three stages due to recruitment challenges and variations in service delivery, valuable insights were nonetheless captured across different time points. Additionally, remote semi-structured interviews were successfully conducted with LINK service workers and referring professionals, enriching the evaluation with a broader range of perspectives.

The evaluation team also conducted semi-structured interviews with members of the Integrated Care Board (ICB) and the LINK service steering group.

All interviews and focus groups were audio-recorded with consent, transcribed, anonymised, and analysed thematically. Routinely collected pseudonymised service data were also analysed to assess the programme's economic impact.

The project recruited participants from five different groups:

1. CYP between the ages of 8 to 19 who had received the service through Barnardo's LINK service.
2. Parents/carers of CYP who had received the service through Barnardo's LINK service.
3. LINK service workers, and LINK volunteers who were employed/volunteer through Barnardo's LINK service.
4. Professionals who made referrals for CYP to the LINK service, including G.P.'s, other healthcare professionals, and school staff.
5. Members of the integrated care board (ICB) and LINK service steering group board.

The evaluation initially sought to undertake an ethical, independent recruitment process. However, despite these efforts, this approach yielded very limited engagement. As a result, and following appropriate approvals, we worked with the LINK service team to help connect us with potential participants who had already expressed interest in taking part. While the final stage of recruitment involved the service facilitating contact, the selection of participants was not directed or influenced by the service, and we maintained ethical oversight throughout.

Qualitative Data

The evaluation team undertook semi-structured interviews with diverse stakeholder groups. CYP were engaged in a manner appropriate to their age and developmental stage. Where applicable, participants were re-interviewed to capture changes over time.

The evaluation team conducted semi-structured interviews with a range of stakeholders (see Figure 7):

Participants group / Activity	Number / Details
Children and Young People (CYP)	22 interviews involving 15 families • 3 participants completed a second interview • 3 participants completed a third interview
Coordination role participants	8 interviews with parents and/or CYP focusing specifically on the coordination service
Parents / caregivers	8 solo parent interviews • 11 parents interviewed alongside CYP
Professional referrers	9 interviews with professionals referring into the LINK service
Programme staff (strategic and operational)	17 scoping interviews with LINK service staff
Programme Board members	9 interviews
Staff focus group	1 focus group exploring the coordination role in greater depth
Workshops	1 Theory of Change workshop • 1 Logic Model workshop

Figure 7. Data collected during the evaluation

Quantitative Data

The evaluation team obtained pseudonymised CORS data sets for LINK service beneficiaries (N=1,064).

Context of Child Outcome Rating Scale (CORS) data

In the context of our evaluation, Child Outcome Rating Scale (CORS) was used by the service to assess service impact. While CORS is a validated tool for assessing children's psychosocial functioning, it is relatively basic for gauging the broader impacts of social prescribing programmes. This tool was chosen as there is currently no standardised outcome measure for CYP undertaking social prescribing and other relevant measurement tools have only been validated in adult populations.

The subjective nature of self-reported outcomes that are used in CORS can introduce biases and data inaccuracies, making it difficult to capture the nuanced effects of social prescribing interventions. This challenge is also reflected in the broader literature. The service utilised the IAPTUS case management system which is a specialised patient management system designed for use within the UK's Improving Access to Psychological Therapies (IAPT) programme. Due to the limitations of the CORS data, we advise only cautious interpretation of results and echo the need reported by other researchers for more robust, comprehensive, and standardised approaches to evaluating social prescribing's economic impact as articulated by Polley et al (2023).

Data Analysis

Qualitative analysis

Thematic Analysis of the qualitative data was undertaken, guided by the evaluation's learning questions (Braun and Clarke, 2021). Two researchers conducted the coding, with one additional team members reviewing and verifying preliminary themes to ensure analytical rigour. Representative anonymised quotes are included in the findings section, identified by stakeholder group to protect confidentiality.

Quantitative analysis

Four levels of analysis were conducted:

1. Descriptive analysis of LINK service data
2. A cost per child analysis
3. An effectiveness analysis using the Child Outcome Rating Scale (CORS) data.
4. A cost-effectiveness analysis

The evaluation team conducted a descriptive analysis of outcome data from the LINK service using the Children's Outcome Rating Scale (CORS). The dataset was provided in long format, with multiple entries per child corresponding to repeated measurement points. Data cleaning was undertaken to remove exact duplicates and implausible values. A unique patient identifier was used to calculate the number of completed CORS entries per individual.

To ensure a reliable estimate of individual change over time, only those children and young people (CYP) with at least 10 CORS data points were included in the cost-effectiveness analysis, as this threshold provides sufficient data to model a meaningful outcome trajectory. Participants who had less than 10 data points do not provide enough information to clearly understand outcome changes over time. Including these participants could lead to misleading results as it is hard to know whether any change

seen is meaningful, short-lived, or simply due to missing information rather than the effect of the service.

Mean scores were calculated at each time point, and longitudinal change in CORS scores was examined using repeated-measures analysis to assess patterns of improvement over time.

The cost-effectiveness analysis (CEA) compared the total programme cost to the outcomes achieved among CYP with valid CORS data. Notably, the CEA was only conducted on CYP who had undergone the 1:1 support pathway because no CORS data was collected for those who had undergone the coordination only pathway. Programme cost information was drawn from Barnardo's financial records (inception of programme in 2022 to July 2025) and included LINK service worker and coordinator salaries, overheads, and programme management. The cost per beneficiary was calculated by dividing total costs by the number of CYP with outcome data. Effectiveness was defined as a ≥ 5 -point improvement in CORS scores, a threshold considered a clinically meaningful gain. This threshold is justified, as CORS/ORS documentation indicates that a change of 5 points or more is often treated qualitatively as reliable change.

The cost per child achieving this threshold was then estimated across three scenarios (50%, 60%, and 70% of beneficiaries showing meaningful improvement). In addition, the cost per point of average improvement in CORS was calculated, and ROI estimates were developed under varying assumptions about avoided downstream costs to the NHS.

Ethical considerations

The study was approved by Barnardo's Research Ethics Committee (Ref: BREC [35] 2022). Ethical issues were addressed by ensuring that all participants were informed about the purpose of the evaluation and only contacted by the evaluation team if they gave prior consent. Informed consent was obtained from all participants prior to any data being collected.

Findings

Introduction to the Findings

This section presents the key findings from the evaluation of the Barnardo's LINK service. The results are organised around the three overarching evaluation questions:

- (1) What **impact** is the LINK service creating and how?
- (2) To what extent is the service being **implemented** in line with plans and stakeholder expectations?
- (3) What enablers and barriers affect the **sustainability** of the service?

The section begins with an analysis of the quantitative data, which explores service reach, demographic characteristics, and measurable outcomes using the Child Outcome Rating Scale (CORS) and cost-effectiveness modelling.

It then turns to the qualitative findings, which draw on interviews and focus groups with CYP, parents and carers, staff, referrers, and commissioners. Together, these findings provide a comprehensive picture of the LINK service's impact, implementation, and sustainability across individual, family, community, and service levels.

Quantitative Findings: Service Reach, Outcomes and Cost-Effectiveness

This subsection summarises the quantitative results from routinely collected service data and outcome measures (IAPTUS data). It provides an overview of who accessed the LINK service, the nature of their needs, and the measurable changes in wellbeing over time, followed by an assessment of the programme's cost-effectiveness and benchmarking against comparable interventions. This section reflects the analysis of LINK service data between March 2022 and July 2025.

Demographics

Age at Referral

The age profile of beneficiaries ranged from 2 to 19 years, with the largest proportions falling between ages 11–15, peaking at age 13 (13.7%). This indicates that the programme most frequently engages early to mid-adolescents, aligning with the onset period of many emotional and mental health difficulties (see figure 8).

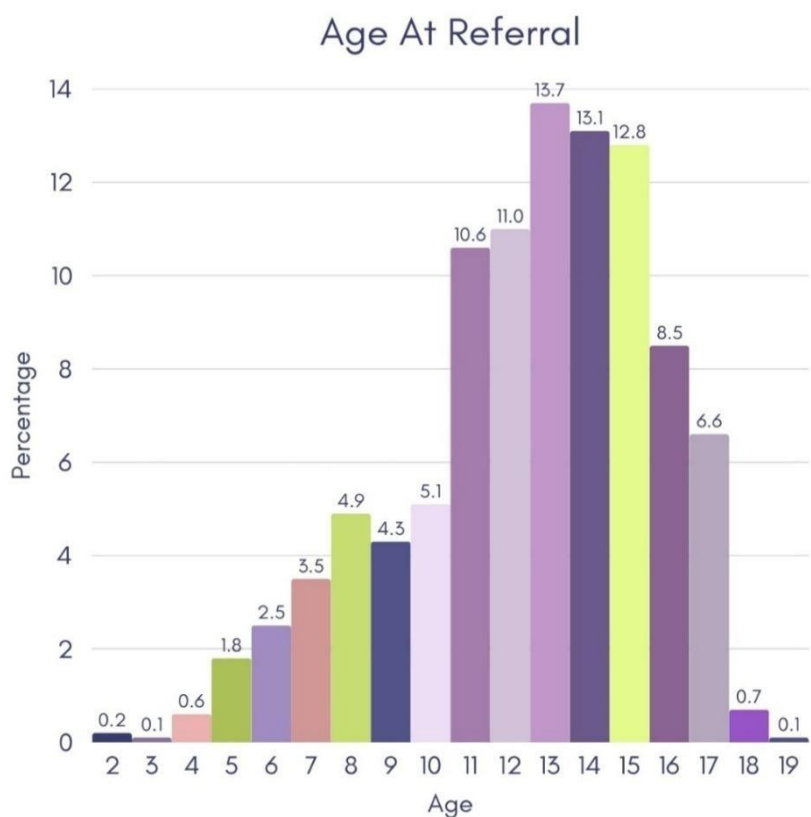


Figure 8. Age of participants

Gender

The majority of CYP supported by the LINK service identified as female (62.6%), with 36.7% identifying as male, and 0.7% as non-binary. These figures reflect a predominance of girls and young women accessing the programme, which may align with patterns observed in early-intervention mental health services, where emotional and internalising difficulties are more commonly reported among women.

There was a notable increase in referrals between ages 10 and 11 which likely reflects the combined impact of educational and developmental transitions rather than a sudden onset of difficulties. This age coincides with the transition from primary to secondary school, during which academic, social, and organisational demands increase, making existing difficulties more visible. It also aligns with the onset of early adolescence, a period characterised by heightened emotional demands and increased expectations for self-regulation (see figure 9).

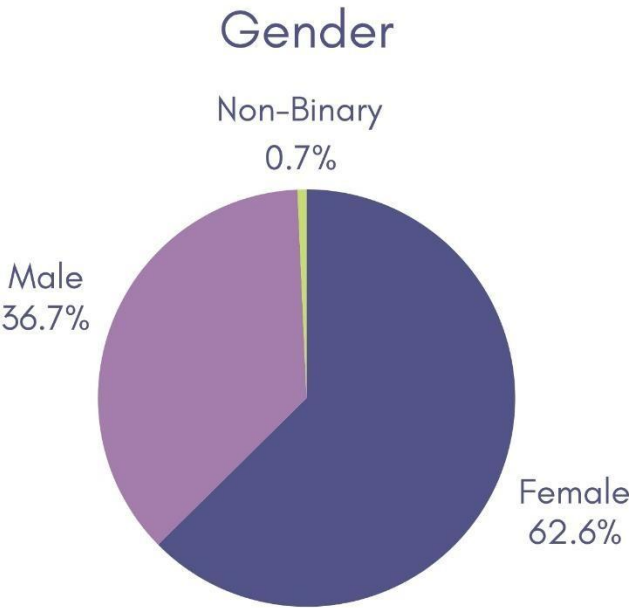


Figure 9. Gender of participants

Gender Identity

Most participants (61.3%) reported that their gender identity was the same as that assigned at birth. However, a substantial proportion either declined to answer (16.2%) or were not asked the question (20.1%). Only a small fraction (0.7%) identified as having a different gender identity from birth, highlighting the importance of inclusive data practices and sensitive inquiry in this area (see figure 10).



Figure 10. Gender identity at birth

Religion

Most young people did not provide information about religion (91.5%) during assessment. Among those who did, small numbers identified with specific Christian denominations (e.g., Church of England 0.7%, Catholic 0.1%) or as non-practising. The high level of missing data limits the conclusions that can be drawn about the religious backgrounds of participants (see figure 11).

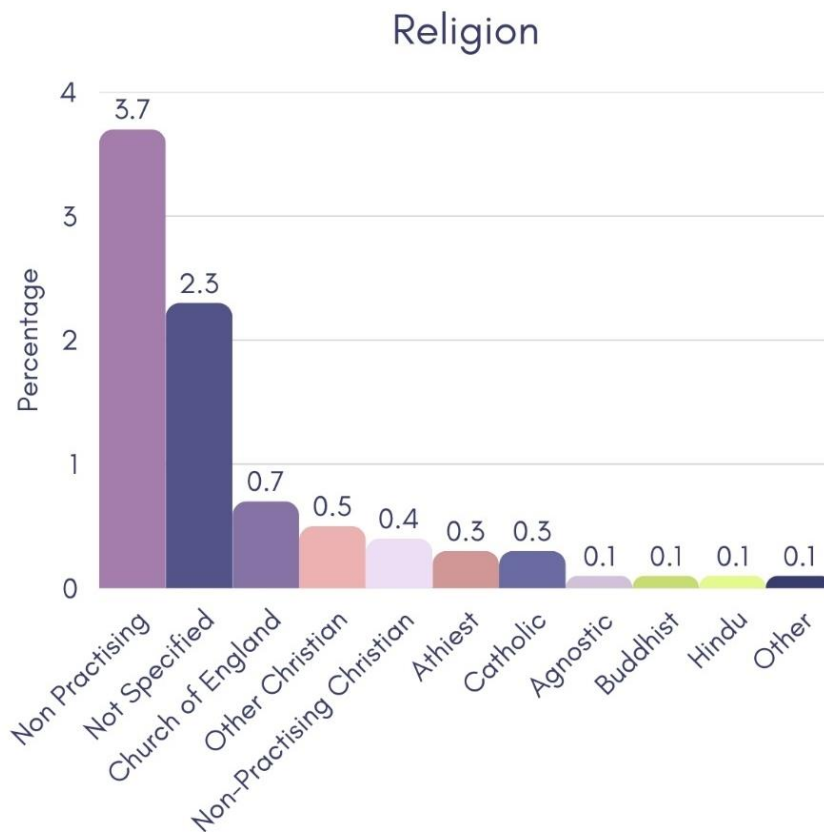


Figure 11. Religion of participants

Ethnicity

The majority of CYP were recorded as White British (65.3%), with other recorded ethnicities including “Any other White background” (1.8%), “African” (0.5%), “Pakistani” (0.1%), and various mixed or unknown categories. Around 30% of records had no stated ethnicity, which again affects interpretation (see figure 12).

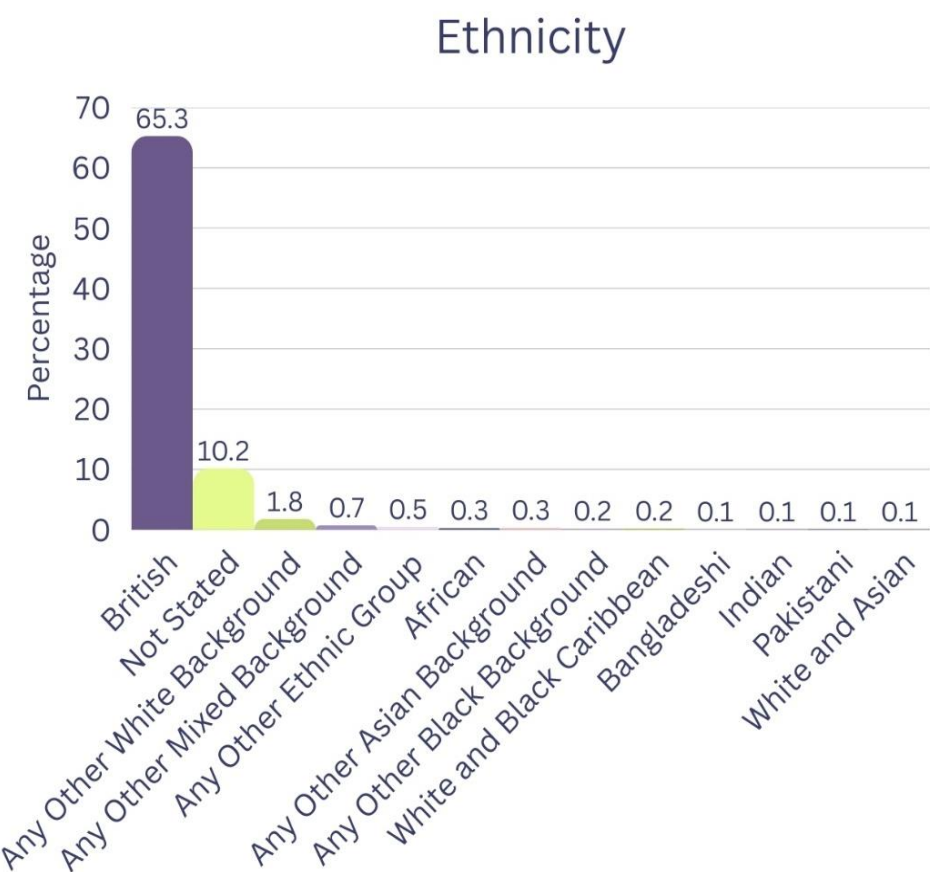


Figure 12. Ethnicity of participants

Additional Needs

Approximately 18% of participants were recorded as having additional needs, while 44.3% were noted as having no perceived additional needs. Notably, 37.7% of cases had no additional needs information recorded, indicating scope to strengthen the programme’s additional needs data recording (see figure 13).

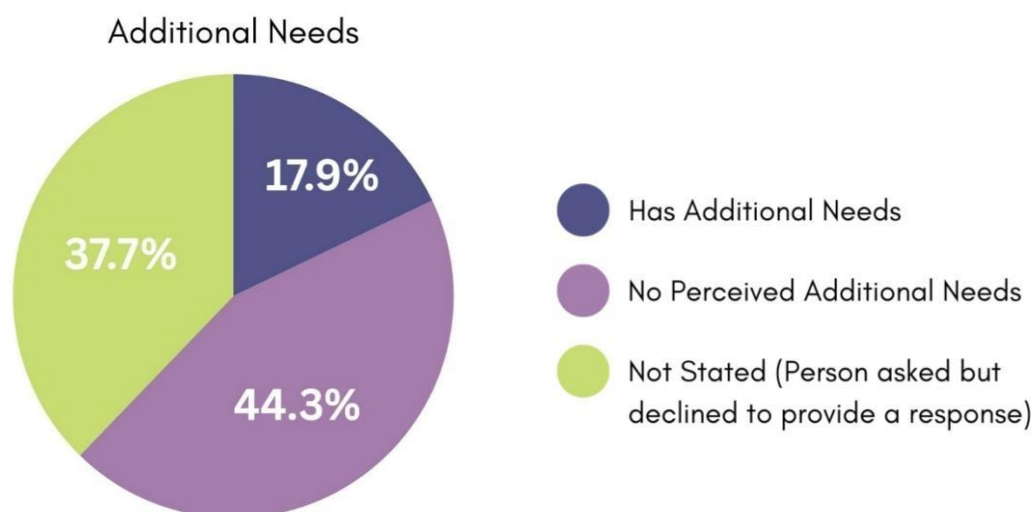


Figure 13. Additional needs of participants

Type of Additional Needs

Among those who reported additional needs, the most common were being on the ADHD or autism pathway (4.4% and 4.2% respectively), followed by diagnosed ADHD or autism (both 2.2%). A small number of young people reported learning needs, physical impairments, or sensory impairments. Most CYP did not provide information about additional needs (82.1%) (see figure 14).

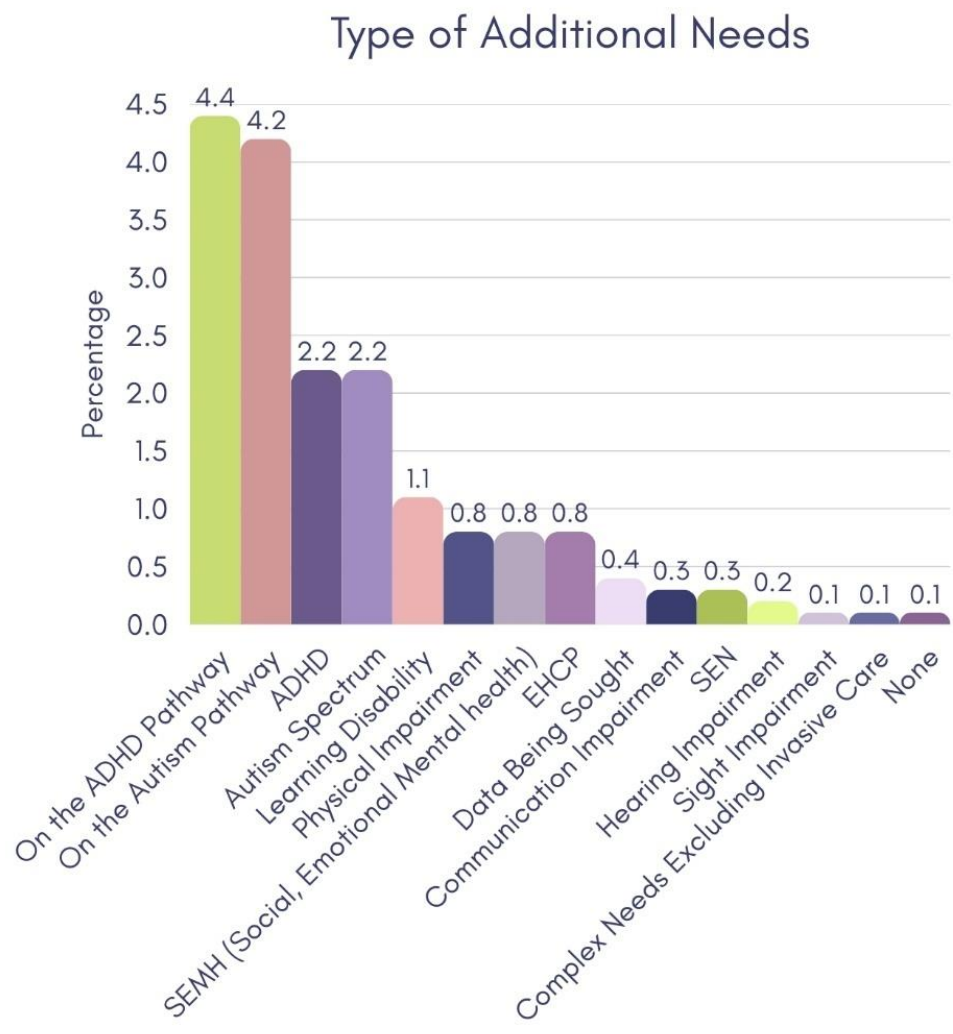


Figure 14. Types of additional needs

Sexual Orientation

Unfortunately, 94.9% of participants did not provide information on sexual orientation. Of those who did respond, the majority identified as heterosexual (2.6%) or bisexual (1.2%), with very small numbers identifying across other categories. As with religion, this highlights challenges in collecting sensitive demographic data among young service users (see figure 15).

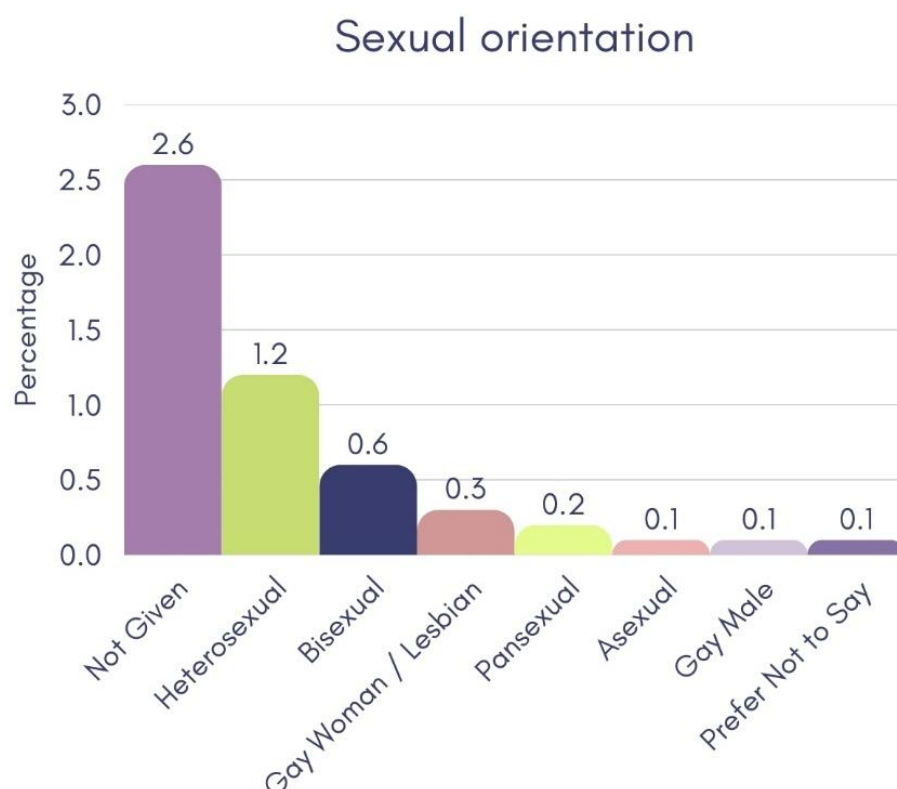


Figure 15. Sexual orientation of participants

Referral Source

The most common referral pathway was via General Practice (63.4%), followed by education providers (27.1%). A small number of referrals came from local authorities, voluntary sector organisations, families, or self-referral routes. This confirms that the LINK service is well integrated with primary care and educational settings (see figure 16).

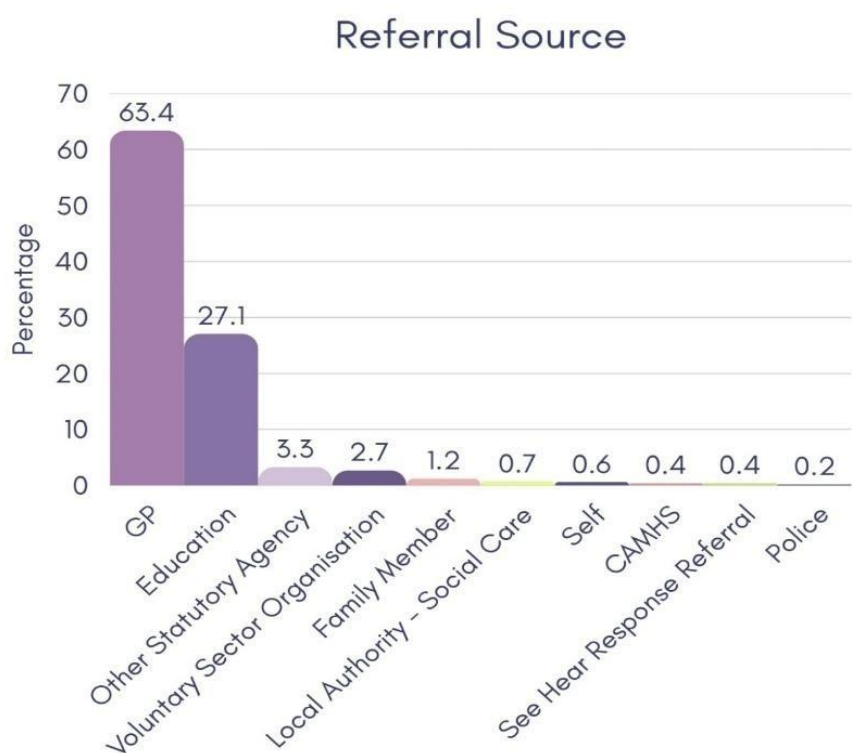


Figure 16. Source of referral into the service

Primary Reason for Referral

The most common reason for referral was anxiety (33.2%), followed by general emotional wellbeing support (15.2%) and emotional regulation difficulties (7.9%). A wide range of other referral reasons were reported, including low mood, suspected autism, self-harm behaviours, bullying, and bereavement. Less frequent reasons (each representing under 1% of referrals) included depression, eating disorders, trauma or abuse, ADHD, panic attacks, family conflict or domestic abuse, obsessive compulsive behaviours, phobias, loss and separation, worries about gender identity, behavioural difficulties, relationship issues, unexplained physical symptoms, neurodevelopmental conditions, parental mental health or substance misuse, bereavement-related or significant life events, and other social or emotional challenges such as homelessness, risky behaviour, or worries about growing up. The variety and distribution of reasons suggest that the programme caters to a broad spectrum of non-acute mental health and emotional wellbeing needs (see figure 17).

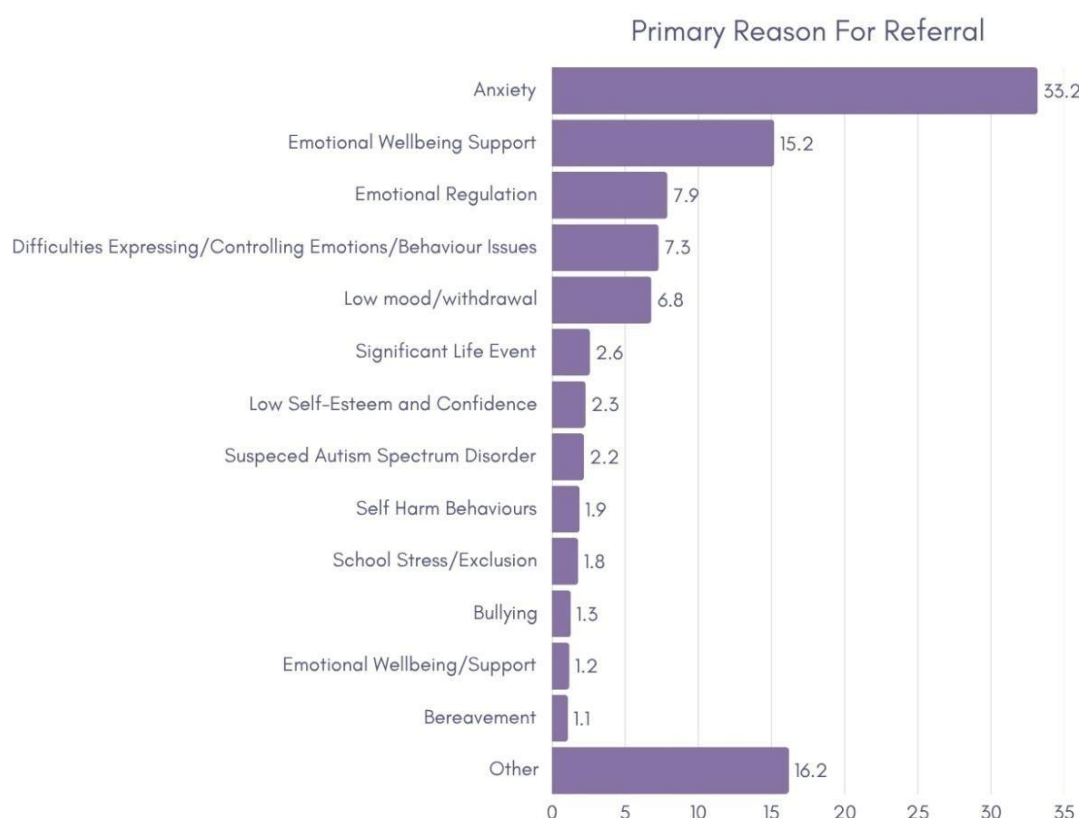


Figure 17. Reason for referral into the service

What Impact is the LINK Service Creating and How?

The programme collected data for 1:1 pathway programme beneficiaries using the Child Outcome Rating Scale (CORS). The coordination workstream formed a key element of the overall programme offer; however, no routinely collected outcome data, such as CORS or equivalent standardised instruments, were available for this strand, meaning its impact could not be assessed in the same way as the 1:1 support pathway. Whilst CORS is a validated instrument (Casey et al, 2020), the literature suggests that there is little known about how and under which circumstances CORS is typically being administered. The scale itself is a linear sliding scale with no step marks which may create data input errors and is prone to various rater biases.

Cost Per Child Analysis

The total delivery cost of the programme was £991,233, including staffing, infrastructure, travel, management, governance, and learning (some of which came from the evaluation during the learning partnership). During this time, the programme was delivered to 371 outcome-assessed participants who received the 1:1 pathway. This resulted in an estimated average cost of £2,671.79 per child who experienced

the 1:1 pathway. Importantly, this figure represents the mean programme cost associated with each child (outcome assessed) and should be interpreted as an overall indicative cost.

The cost-effectiveness analysis below draws on total programme costs but measures outcomes solely for the 1:1 pathway, the resulting cost-effectiveness ratio may appear challenging from a programme perspective, given that a substantially higher number of young people were reached through the wider coordination workstream for which comparable outcome data were not available.

Effectiveness

We used a mean predicted CORS score to illustrate the average change observed across the cohort of children and young people for whom outcome data were available (1:1 support pathway only). This aggregate measure indicates a general trend of improved psychosocial wellbeing over the course of the intervention, irrespective of individual variability in response. While individual responses varied, the average gain provides a robust population-level estimate of programme effectiveness, aligning with evaluation standards in early mental health support interventions.

On average, CYP entered the programme with a CORS score of approximately 27 and improved by around 0.7 points per session, reaching a mean final score of ~34 after 10 sessions. This reflects an average 7.3-point gain, which is considered clinically meaningful, exceeding the commonly referenced 5-point improvement threshold (see figure 18).

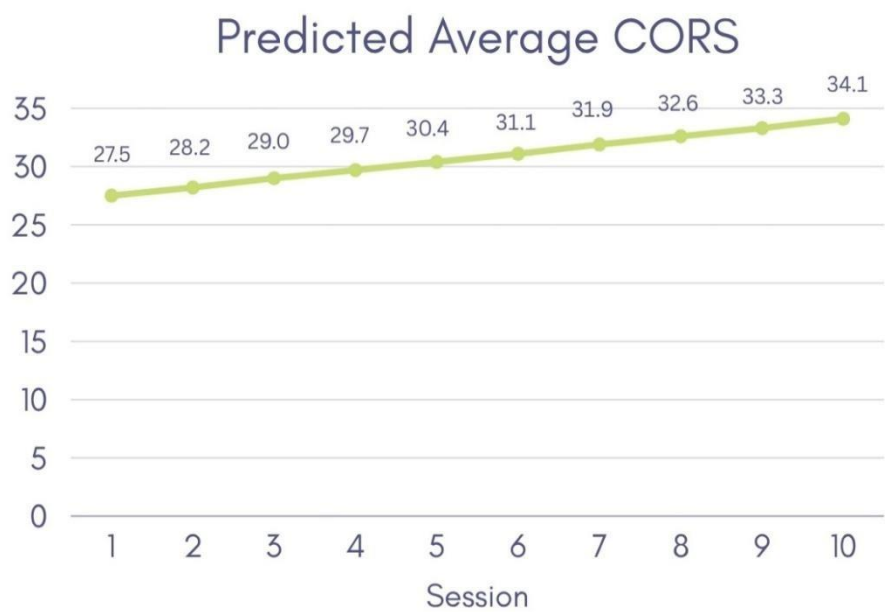


Figure 18. Predicted average CORS.

Cost-Effectiveness Analysis

To assess the value of the LINK service in economic terms, a cost-effectiveness analysis (CEA) was conducted using data from 371 CYPs for whom CORS (Child Outcome Rating Scale) scores were available across multiple time points.

The CEA was only conducted on CYP who had undergone the 1:1 support pathway because no CORS data was collected for those who had undergone the coordination pathway. These data were used to estimate both the average clinical gain per child and the cost per meaningful outcome.

Unlike a simple cost analysis (cost per child), which simply calculates the total cost of delivering a programme or intervention, the cost-effectiveness approach calculates the cost per demonstrated outcome, offering a more rigorous and transparent assessment of programme value by linking costs to measurable effects.

Cost Inputs

The total programme expenditure was £991,233, including staff costs, delivery infrastructure, and coordination expenses. Evaluation costs were also included because the programme benefitted from learning partnership insights that likely improved its overall effectiveness. These costs were allocated across the 371 outcome-assessed participants for the purpose of calculating unit cost estimates.

Cost-Effectiveness Ratios

Using a base case scenario, the average improvement observed across the cohort of 371 CYP with CORS outcome data was 7.3 points. When total programme costs (£991,233) were divided across this group, the average cost per participant was calculated to be approximately £2,671.

To provide a more granular understanding of cost-effectiveness, the cost per unit of clinical improvement was also estimated. Based on the total number of points gained across all participants (371 individuals × 7.3 points), the cost per CORS point gained was approximately £368.

Recognising that not all participants may have experienced a clinically meaningful improvement, several scenarios were modelled using a 5-point gain in CORS scores as the threshold for meaningful change. The resulting cost per improved child varies depending on the assumed proportion of CYP who reach this threshold:

- If 80% of participants improve meaningfully, the cost per improved child is approximately £3,336.

- If 60% improve, the cost rises to £4,448.
- At 40%, the cost increases to £6,672.
- In a conservative scenario where only 20% show meaningful improvement, the cost per improved child is approximately £13,343.

These figures offer a flexible framework for interpreting the programme's value, depending on various assumptions that were accounted for through a benchmarking exercise.

Benchmarking the LINK Service Against Comparable Interventions

To contextualise the findings of the cost-effectiveness analysis, a rapid benchmarking exercise was undertaken to compare the LINK service with other early intervention or social prescribing models aimed at supporting CYP mental health in the UK. The purpose was to assess whether the cost per meaningful outcome achieved by the LINK service aligns with comparable services operating in similar non-acute, community, or school-based settings. Several relevant UK-based studies and evaluations reporting cost-effectiveness or cost-per-outcome figures for comparable interventions were identified. It should be noted that these programmes offered different interventions to our programme.

- ETHOS Trial (Cooper et al., 2021) evaluated school-based humanistic counselling and reported an average improvement of approximately 2 points on the YP-CORE scale at a cost of £4,635 per participant. This is notably higher than the LINK services estimated £2,671 per participant, with the LINK service also showing larger mean improvements (7.3 CORS points) (Cooper et al., 2021).
- Incredible Years Parenting Programme demonstrated cost-effectiveness with a cost per child in the region of £1,177–£2,380, depending on the modelled outcomes and settings. These figures are broadly comparable to the LINK service's cost per child with a clinically meaningful improvement (£3,336 at 80% responder rate) (Edwards et al., 2016).
- Economic modelling by Bonin et al. (2011) projected long-term savings of £5,837–£13,000 per case of persistent conduct disorder averted, aligning with potential ROI estimates from the LINK service if downstream impacts (such as reduced CAMHS use or improved school engagement) are realised (Bonin et al., 2011).

Collectively, these benchmarks suggest that the LINK service offers comparable or better value for money than similar interventions, particularly when the per-child cost is paired with meaningful CORS score improvements. However, unlike some comparator programmes, the LINK service's strength lies in its integration with primary care and whole-family SP approach, offering potential systemic benefits beyond individual-level mental health outcomes.

When benchmarked against these programmes, the LINK service sits comfortably within an expected cost-effectiveness range, particularly when considering its broader SP model and its ability to engage CYP not yet accessing formal CAMHS pathways. It suggests that the LINK service delivers impact at a competitive cost, particularly given the complexity and diversity of the young people supported.

Moreover, unlike more narrowly targeted school-based programmes, the LINK service operates at the interface between primary care, family support, and community infrastructure, potentially enhancing long-term system savings through early de-escalation of need. These features, combined with measurable improvements in wellbeing, provide strong evidence of strategic fit with current early-intervention priorities in children's mental health services.

Interpretation of analysis

Compared to other UK-based early mental health interventions (see benchmarking analysis), the LINK 1:1 support pathway shows competitive unit costs per improved child, especially in the context of a non-acute, community-based intervention targeting a broad range of emotional and psychological needs. The average improvement of 7.3 CORS points exceeds clinical significance thresholds and compares favourably with similar services in school or primary care settings.

Summary of Quantitative Findings

The quantitative analysis indicates that the LINK service reached a broad and diverse group of children and young people, most commonly those aged 11–15. Anxiety and general emotional wellbeing difficulties were the primary reasons for referral, with most referrals originating from GPs and schools.

Outcome data show a clinically meaningful average improvement of 7.3 points on the CORS scale, reflecting sustained gains in emotional wellbeing. Cost-effectiveness modelling places the LINK 1:1 support pathway within, and in some cases below, the expected cost range for comparable early intervention and community-based programmes. When benchmarked nationally, the LINK service demonstrates both measurable impact and value for money, reinforcing its role as an effective early-help model within Cumbria's integrated system of care.

These findings provide an important quantitative foundation for the following section, which explores in greater depth, through qualitative data, how and why these improvements were achieved for children, young people, and families.

Qualitative Findings

The following section presents qualitative findings from interviews conducted between early 2022 and June 2025 with CYP, parents and carers, LINK service workers, referrers, and commissioners. The analysis is structured according to the three overarching evaluation questions developed through the learning partnership:

- 1. What **impact** is the LINK service creating, and how?
- 2. To what extent is the LINK service being **implemented** in line with plans and stakeholder expectations?
- 3. What enablers and barriers affect the **sustainability** of the LINK service, and how?

Each subsection draws on the voices and perspectives of multiple stakeholders to explore how the service delivers change, how it has been implemented across systems, and what factors support or constrain its long-term sustainability.

Participants

There were 15 CYP, 27 parents, and 10 referrers. The CYP ranged in age from 8 to 17 years, with the largest group being those aged 12 (n=4). Within this group, eight participants identified as male and used he/him pronouns, and seven identified as female and used she/her pronouns. All twenty-seven parents identified as female and used she/her pronouns (see Figure 19).

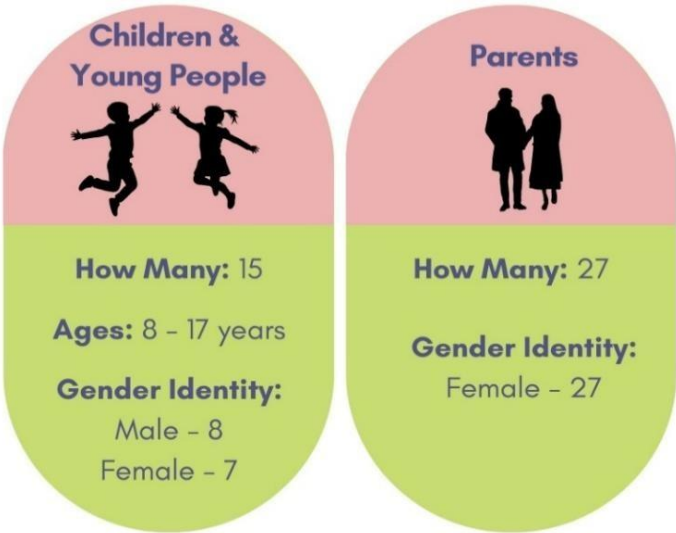


Figure 19. Participant characteristics

The referrers represented a range of professional backgrounds, most commonly school staff (n=4), and GPs (n=3), alongside a commissioner (n=1), a nurse (n=1), and college staff (n=1).

1. What Impact is the LINK Service Creating and How?

This section explores how the LINK service supports change for children, young people, and families, focusing on the mechanisms through which it delivers early intervention, strengthens wellbeing, and builds resilience across home, school, and community settings.

Prevention and Early Intervention

The qualitative findings demonstrate that the LINK service functions as an effective early help offer, preventing the difficulties experienced by CYP from escalating into more severe mental health problems. Interviews across stakeholder groups revealed five core mechanisms underpinning this preventative impact (Figure 20). Together, these mechanisms show how the LINK service’s early, relational, and flexible approach promotes stability, confidence, and resilience among CYP and their families.

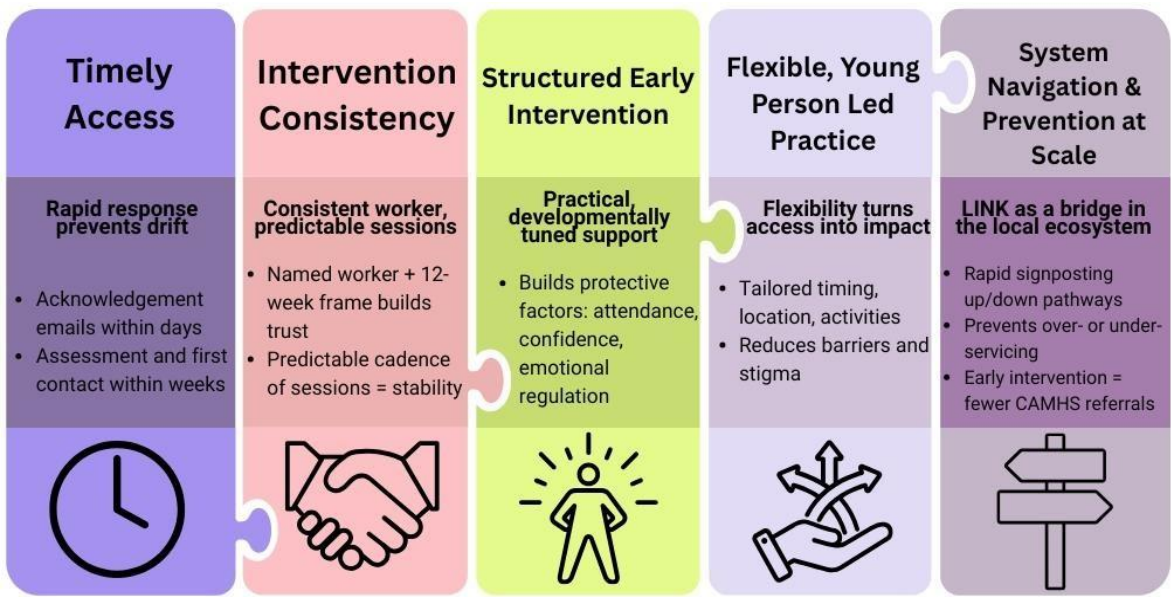


Figure 20. Building blocks of prevention and early intervention

Mechanisms of Impact

1. Timely access ensured concerns were acknowledged and acted upon quickly.
2. Intervention consistency provided stability through a consistent worker and predictable session structure.

3. Structured early intervention offered practical, developmentally attuned support that strengthened protective factors such as confidence and emotional regulation.
4. Flexible, young person-led practice tailored delivery to individual needs, reducing barriers to engagement.
5. System navigation and prevention at scale positioned the LINK service as a bridge within the system, ensuring appropriate referrals and sustaining early help capacity across services.

Timely Access

Rapid acknowledgement and early assessment prevent difficulties from worsening and provide reassurance to families and schools that help is on the way. Across interviews, stakeholders consistently emphasised the importance of swift action, noting that timely contact after referral helped prevent young people from “drifting” while waiting for statutory support. The ability to respond within weeks rather than months was described as a major strength of the service, providing a visible sense of containment during periods of uncertainty.

“The service works on an early intervention basis. It is lower level. It is stopping that escalation of mental health need for young people, getting to level three, and then requiring statutory intervention.” LINK service worker 13

The combination of prompt communication, initial assessments, and quick allocation of LINK service workers was described by parents and referrers as both relieving and motivating, signalling that concerns were being taken seriously and acted upon quickly.

Intervention Consistency

Consistency with a named worker and a predictable session structure promotes trust and stability, which are essential for sustained engagement. Having a dedicated worker over a defined twelve-week period gives CYP a sense of safety and reliability. This continuity allows relationships to deepen, enabling LINK service workers to notice subtle changes or early warning signs before issues escalate. Referrers observed that the service’s structure helped young people “show up and stay engaged,” as they understood both the purpose and the timeframe of the support.

“No, I have been really impressed with how fast it's come in because obviously [my child] was struggling with school for a couple of weeks and when we were told it could be 6 to 9 months waiting list to start

off with. It felt a very long way in the future and that was we may have passed that point at that time. But obviously those issues will still have been there. So, I think the speed has been really, really helpful. [...] it's been a really lovely service for [young person] just to have a bit of time for him to go through his worries" Parent 4

This structured regularity, weekly contact, consistent timings, and the same trusted worker, was viewed as central to the LINK service's success in providing stability for young people whose circumstances or support networks were often fragmented.

Structured Early Intervention

The LINK service's practical, developmentally attuned approach strengthens protective factors such as confidence, attendance, and emotional regulation. The model includes psychoeducation, decider skills, nature-based work, and utilisation of community-based assets.

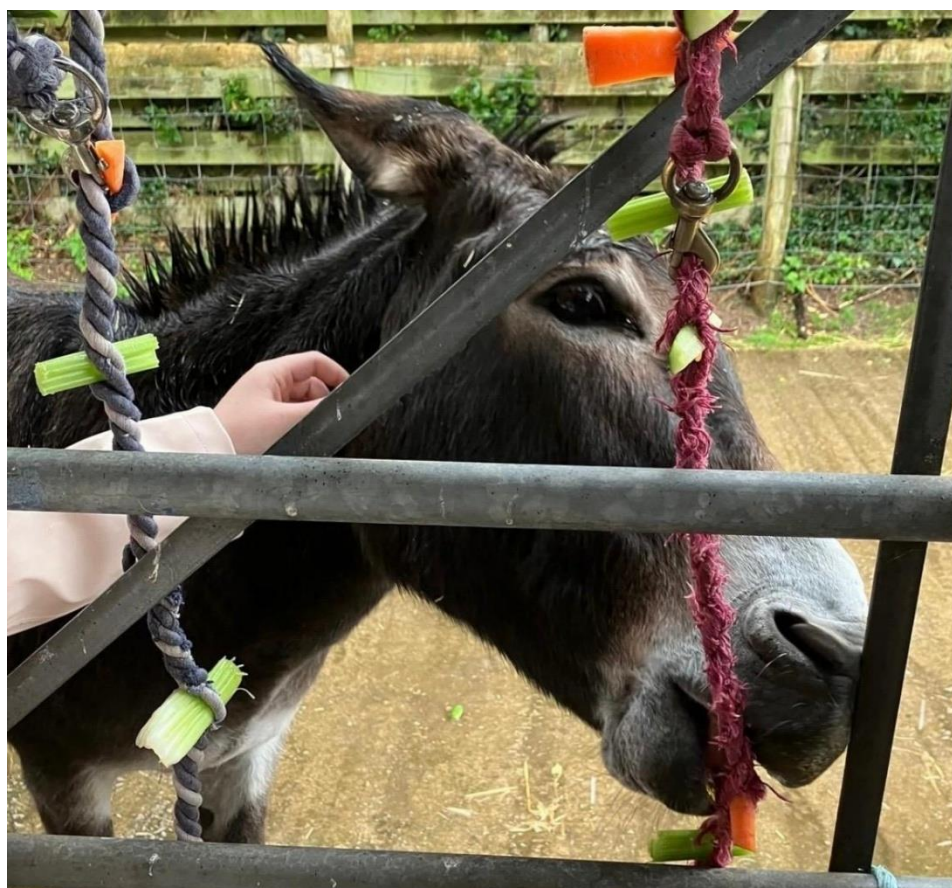


Photo 2. CYP visit to local community-based asset.

The service's structured model enables young people to develop coping strategies that can be applied across contexts, including school and home. Referrers and staff described this as a process of "small but significant shifts," where improved routines, renewed engagement in education, and reduced anxiety-built momentum for sustained wellbeing.

"Well, they've taught me a lot about how the brain works and different reactions we could have to things. One of the main ones being like fact or opinions, like, if I'm thinking something it's only an opinion because the fact of the matter is someone's done something and I've just started coming up with all these possibilities and they're all opinions. And that's kind of helped me to understand because I did get it wrong last night, but I understand it now that they're re-explained." Young person 2, age 15

The focus on proactive, skills-based support allows CYP to rehearse and test new behaviours in real time, rather than waiting for crisis points to arise.

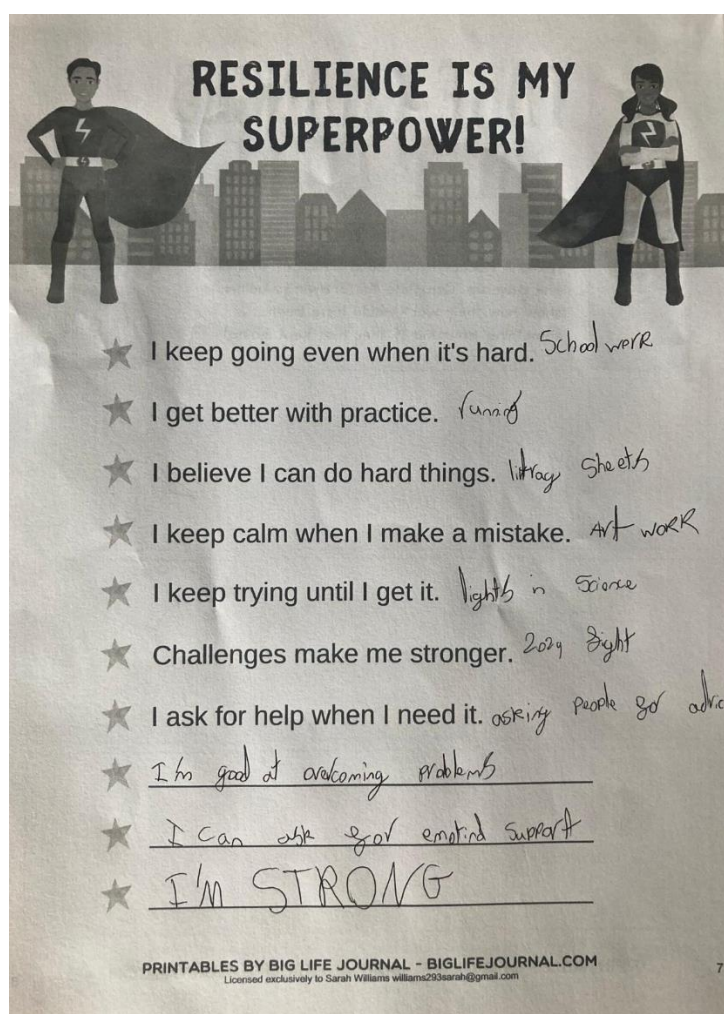


Photo 3. Development of coping tools during 1:1 sessions.

These incremental, observable gains, such as attending school regularly or managing emotional triggers, reflect the preventive nature of the LINK service's work, positioning it as a bridge between universal services and more specialist mental health support.

Flexible, Young Person-Led Practice

Sessions are tailored around each young person's needs, timing, and preferred setting: at school, home, or in community spaces. This flexibility reduces barriers and stigma, ensuring engagement remains high even among those who have previously struggled to connect with services. LINK service workers emphasised that young people are given genuine ownership over their sessions, with activities and discussions adapted to their comfort and interests.

"Because every session is led by the young person. It's their session, it's for them and we're working for them. It's not us telling them what they should do. It's working out between us. It's their session, it's young person led." LINK service worker 11

The non-clinical, relational nature of this approach helps to lower resistance and encourage participation. By meeting CYP in spaces they find safe and familiar, LINK service workers can model choice, agency, and collaboration, key principles that underpin self-efficacy and confidence.

System Navigation and Prevention at Scale

The LINK service operates as a bridge within the local ecosystem, connecting CYP to wider community assets and ensuring smooth onward referrals when specialist input is required. This ability to "hold" children and families in the gap between universal and clinical services was described as one of the LINK service's defining strengths. The model reduces both over- and under-servicing by directing CYP to the right level of support at the right time, preserving capacity across the system while maintaining continuity for families.

"They're good at liaising with CAHMS as well. They will kind of help fill in forms. They'll help kind of bridge that gap between kind of the secondary care teams and what's available locally, as in voluntary teams and things as well. So yeah, they're an absolute godsend for us because we honestly without them, I honestly don't know where we'd go now." LINK service referrer 9

This system-navigation function was also evident in how LINK actively supported referrers to make appropriate onward decisions when cases fell outside the service's remit, rather than simply rejecting referrals. Referrers described LINK as helping to

interpret thresholds and identify suitable alternatives, ensuring that children and families were not left unsupported at transition points between services:

“We are provided a criteria of what they do and they don't, which we do get up when we're putting the referral in. So obviously sometimes they do come back as they're too high tariff, but if they are too high tariff, they will then help us find suitable which I think it will then normally go to MyTime or CAMHS or if it's too low tariff, again they'll help us find the ideal service.”

LINK service referrer 1

Schools and health partners described the LINK service as a dependable early-help layer that normalises help-seeking and provides a safety net for children at risk of slipping through gaps. This system-facing function ensures that prevention operates not only at the level of individual young people but also across services, improving coordination and overall early-help capacity.

The Impact on CYP's Wellbeing and Quality of Life

The LINK service was described by participants as producing tangible and meaningful improvements in children's and parents' day-to-day emotional states, interpersonal functioning, and engagement with family life. Across multiple parent and young-person accounts the most frequently reported outcomes were reductions in acute anxiety and panic-type responses, improved emotional regulation and calmer household environments, increased confidence and willingness to leave the home and re-engage in everyday social activities, clearer communication within families about feelings and needs, and improved school participation and readiness for next steps (for example exams, college pathways or extra-curricular activity). These outcomes were reported whether the child's presenting difficulties were social isolation, sensory-overload at school, panic-type responses, or long periods of withdrawal. Parents consistently framed the service as filling an important gap between primary care / school-level support and specialist CAMHS waiting lists. The qualitative findings from interviews with CYP are summarised in Figure 21, which illustrates the key areas of improvement described by participants.

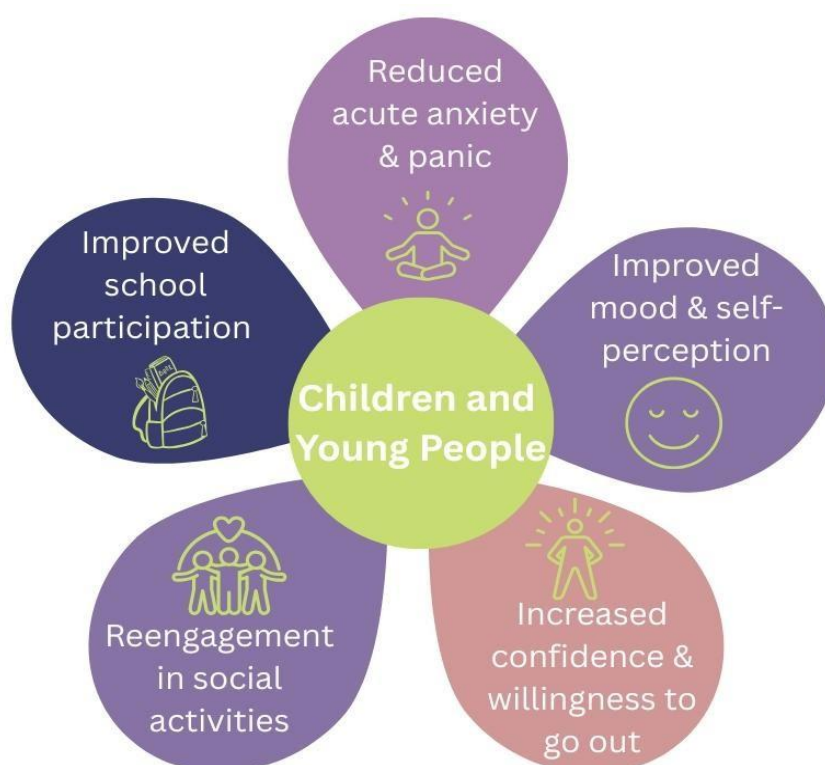


Figure 21. CYP views on the LINK service

It is notable that participants repeatedly highlighted the relational, conversational aspect of the LINK service contact as the key factor in which improvements were made. Parents emphasised that having an independent adult who listened and fed back to the child supported the child to express distress in words rather than through distressed behaviour. This change in mode of expression, fewer behaviour-driven outbursts and more verbalised reflection, was reported to improve family dynamics and parental wellbeing.

"It's the listening, so it's talking and listening as well. So, I think that's maybe what's been lacking in terms of when she's tried to express things to the teachers that she finds difficult or that I've had issues with her, like, not being able to regulate her emotions in the mornings and getting ready for school and stuff like that. I think someone that's actually just taking the time to listen and feedback to her on that. Is really positive. And it feels like that's helped to bring more calm in the household because she's kind of able to go there and talk about it."
Parent 2

The data showed parents associated the child's attendance at LINK sessions with decreases in poor behaviour at home and greater ease with daily routines (getting

ready, leaving for school). The arrival of the LINK service input reduced everyday unpredictability, so the parent no longer woke each morning unsure whether the day would include a meltdown. Parents described this improvement as reducing parental worry and enhancing carers' capacity to cope, outcomes that improved quality of life.

"It definitely feels like she's calmer and she will come home and talk about the sessions and what they've spoke about as well. So that's supporting us to communicate as well as about things that are affecting her." Parent 2

Young people themselves described increases in emotional clarity and a marked improvement in mood and self-perception over a relatively short timeframe, frequently using vivid metaphors to capture change. Several young people described a movement from withdrawal and very restricted daily activity (not leaving the house, intense fear of being judged) to slowly re-engagement with the world. These steps were framed by young people as tangible markers of recovery in mood and confidence, and they spoke about an emergent sense of possibility for future participation in school and social events.

"I literally feel like I was born again. I feel like a different person." Young person 4, age 15

In addition, children reported feeling less impacted by negative thoughts and more able to picture future events (prom, exams, shopping trips) as attainable rather than overwhelming. These improvements were accompanied by practical indicators (attendance at sessions, small outings, engagement with creative projects) that together point to enhanced mood, reduced depressive-like withdrawal, and restored participation in activities.

Linked to improved mood, many young people described increased confidence and tangible steps toward social and situational exposure that they had previously avoided. Two specific improvements were described: (1) emotional reappraisals (less catastrophic thinking, better separation of "fact" from "opinion"), and (2) behavioural action (actually going out). One young person described how the combination of being listened to and being taken out in graded steps produced steady improvements:

"Ever since the start, she's listened to me. She's let me talk, let me get my feelings across, let me vent. And that was enough of a buildup on its own but then we started going out for walks. We went to the park one day." Young person 1, age 13

The findings highlight that being listened to helped young people develop language to describe their experiences and feel validated. This validation, in turn, enabled gradual exposure to new situations that they experienced as confidence-building.



Photo 4. Confidence building activity with CYP during 1:1 session.

Parents reported similar outcomes in terms of the child's school participation, classroom tolerance, and readiness to engage with opportunities that support development (specialist courses, college applications, extracurricular groups). In several parent narratives the LINK services involvement was associated with practical adjustments at school together with improved emotional stability that made classroom participation possible. One parent captured the sense that a previously unmanageable school context had become navigable and that this had relieved both child and parent anxiety:

"I mean she helped with the most difficult time with [son] being at school and now we've taken him away, his anxiety and his issues have calmed down massively. He's happier at home now." Parent 4

Finally, parents consistently reported benefits to their own mental health, sense of hope and family functioning. Several parents used language such as "*life-changing*," "*gold*," or "*phenomenal*" to express how the LINK service input reduced parental

isolation and worry. The reduction in day-to-day crisis events, clearer communication from children about their feelings, and timely practical support from LINK service workers (e.g. help with referrals and liaison with school) were all described as improving parental capacity to support the child. These parental outcomes were both emotional (less fear; better sleep and less hypervigilance) and instrumental (improved routines, calmer family relationships).

The key parental outcomes are summarised in Figure 22, which presents the most reported benefits to family wellbeing.

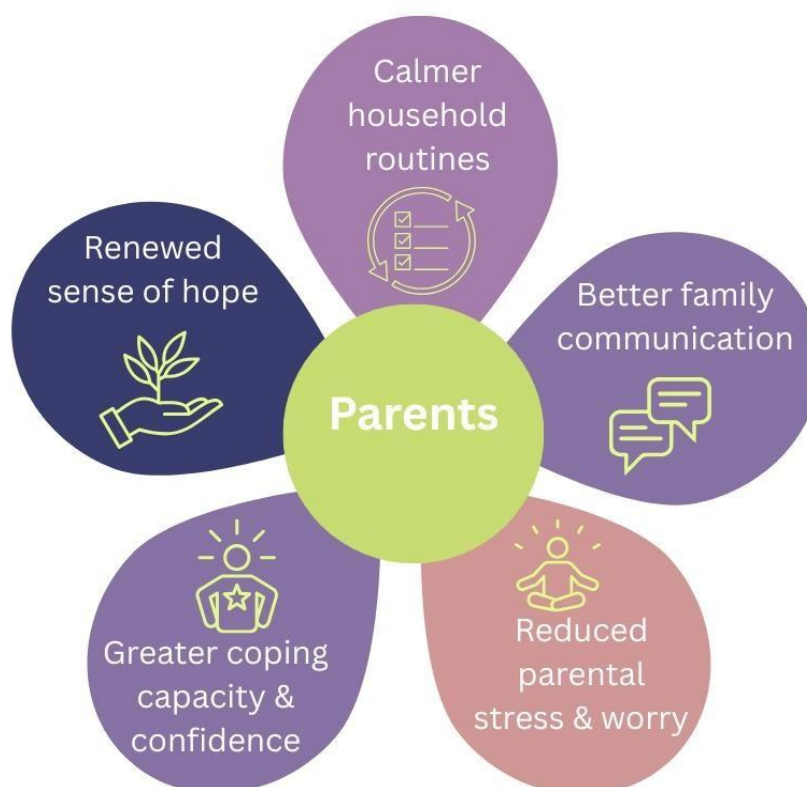


Figure 22. Parent and caregiver views on the LINK service

Taken together, the qualitative interview data describe a cluster of positive outcomes following the LINK service involvement: acute symptom reduction (panic/anxiety), improved emotional regulation (less behavioural acting-out), restored engagement in valued activities (school, social outings, creative work), strengthened family communication, and reduced parental stress. Young people describe regained confidence and a renewed sense of possibility, often over a short time window (months rather than years), while parents describe improved day-to-day household functioning and an increased ability to plan for the child's educational or vocational future.

How and Why is the LINK Service Having an Impact on Families?

The qualitative interview data highlights meaningful change for children and families because of LINK service involvement. The identified themes suggest that impact is generated through *relational processes* - the quality of the relationships formed between the child or young person, their family, and the LINK service worker. These relationships create a foundation of safety, trust, and collaboration from which practical and emotional change can develop.

Figure 23 illustrates the key mechanisms by which positive outcomes were achieved. Together, these mechanisms show how relational containment, skill-building, and systemic coordination work in combination to support both individual and family-level change.

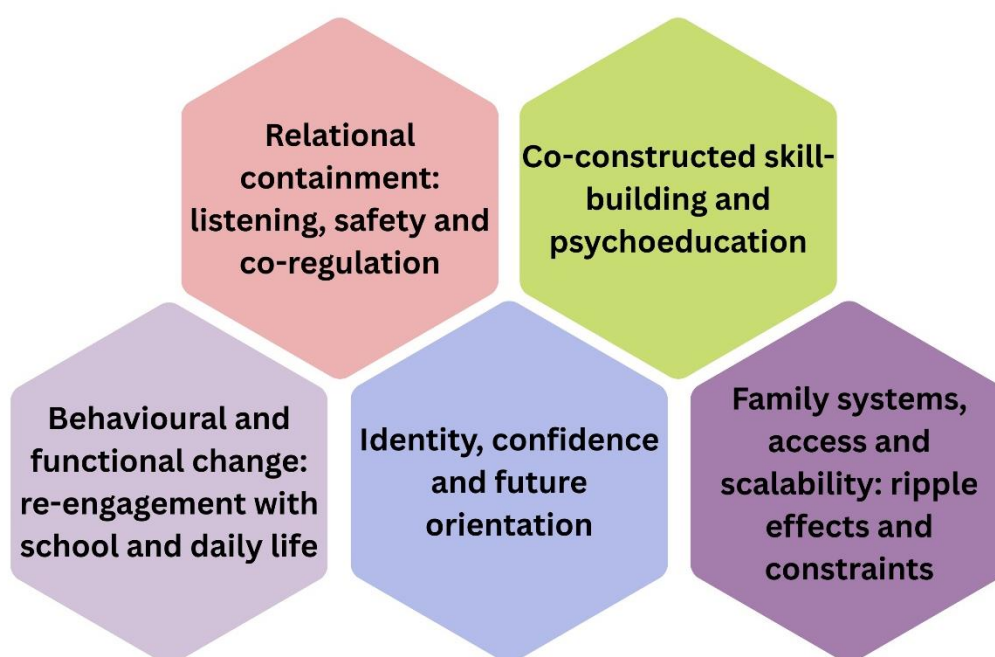


Figure 23. Key mechanisms by which positive outcomes were achieved.

The LINK service workers' capacity to combine consistent listening, reliability, and coregulation with co-constructed skill-building enabled them to support the stabilisation of CYP people as they transitioned across home, school, and community settings. Families described reductions in distress behaviours, improved daily functioning, and renewed confidence, with ripple effects at household and systemic levels. Importantly, these outcomes were cumulative: relational safety enabled the

uptake of skills, which in turn supported behavioural shifts and more stable family routines.

Relational Containment: Listening, Safety and Coregulation

Triangulation of the data across all the interviews revealed that the fundamental mechanism for change was relational: for example, the LINK service workers' capacity to provide non-judgemental, timely, flexible listening, which facilitated calm ways of working with CYP. Families repeatedly described how the LINK service worker's presence, in home, school or community settings, created a tolerable space for children. This took the form of simple but important gestures, for example: the worker arriving when expected, offering choice over venue, shortening or lengthening sessions to match the young person's energy, using session-rating tools so the young person could steer the work, and gently framing difficult moments so that children could feel heard. Parents spoke about a shift from behaviourally expressed distress (meltdowns, morning panic) to communication made possible by a third party who would listen and then feedback to teachers or the family. That process appeared to influence a reduction of household escalation and helped to improve day-to-day quality of life. The relational stance was a practical strategy that allowed parents to step back and children to practise regulated engagement.

"We just knew we desperately needed help, because we didn't know, when you have a child with anxiety, you never know what they're getting up to, and you never know what mood they're going to be in. Even throughout the day, you never know what can trigger, we had no clue. So, when [LINK service worker] said they would like to come and see us, the moment they walked in the door, [Young Person], it just clicked. They are such a lovely, calming influence on [Young Person], and they just clicked, and [Young Person] thoroughly looks forward to her coming every week. The help is just phenomenal."
Parent 1

Parents and young people highlighted that the LINK service worker listening operated as the pivot between distress and regulated expression.

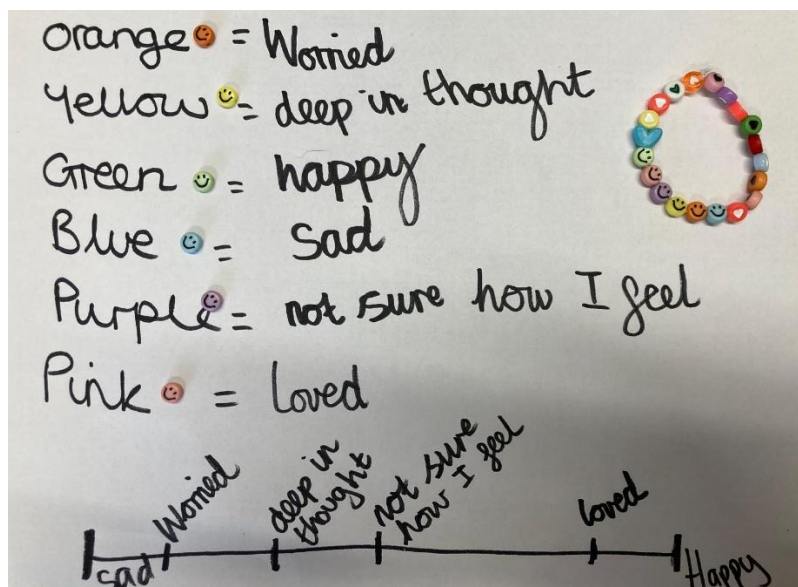


Photo 5. CYP expression of emotions within 1:1 session

Because many families had felt isolated or “on their own” in prior help-seeking. Parents reported that the worker’s attentiveness acted as both a containment device (calming immediate reactivity) and a social translator (helping secure systemic accommodations). This was reflected in the repeated recurrence of statements about “feeling heard” suggests the relational stance created both subjective safety and tangible scaffolds for behaviour change.

Co-constructed Skill-Building and Psychoeducation: Tools that Translate into Practice

The LINK service work was described by CYP and their parents as combining attentive listening with the use of practical, solution-focused tools such as short grounding exercises, behavioural experiments, and negotiated sensory adjustments. Young people valued concrete, explanative metaphors (for example, the window of tolerance) that made emotional reactions logical. Parents valued brief, actionable plans (early lunch passes, time-out strategies) they could use immediately with schools.

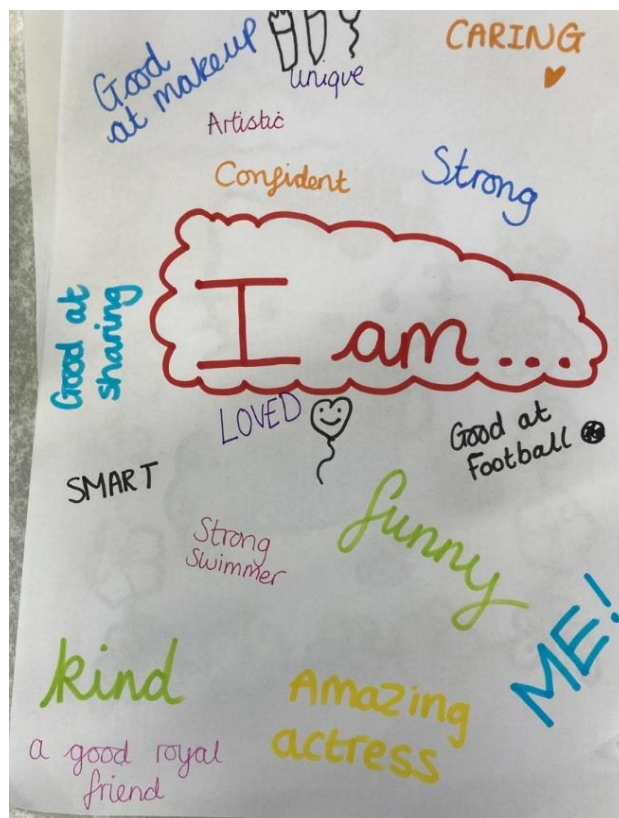


Photo 6. CYP drawings during the development of emotional coping strategies

These tools were rarely delivered as rigid protocols, but they were offered as co-constructed experiments. For example, LINK service workers often used short activities (drawing, walking, gentle graded exposure) to create low-stakes contexts in which a young person could practise newly learned coping strategies.

“Every time they make something, he always brings something home which has a little explanation with it on how it can help him and they've made some fantastic things, some beautiful things and he's got a lovely box that you can keep them all in. It's his Sunday night box for when he's feeling anxious for school the next day.” Young person 3's parent

These strategies were carried forward after the programme ended (for example, ongoing use of earplugs, continued walks, or a retained explanation of the window of tolerance), which illustrates how these ‘tools’ could be transferred into everyday self-management and maintenance of improvements.

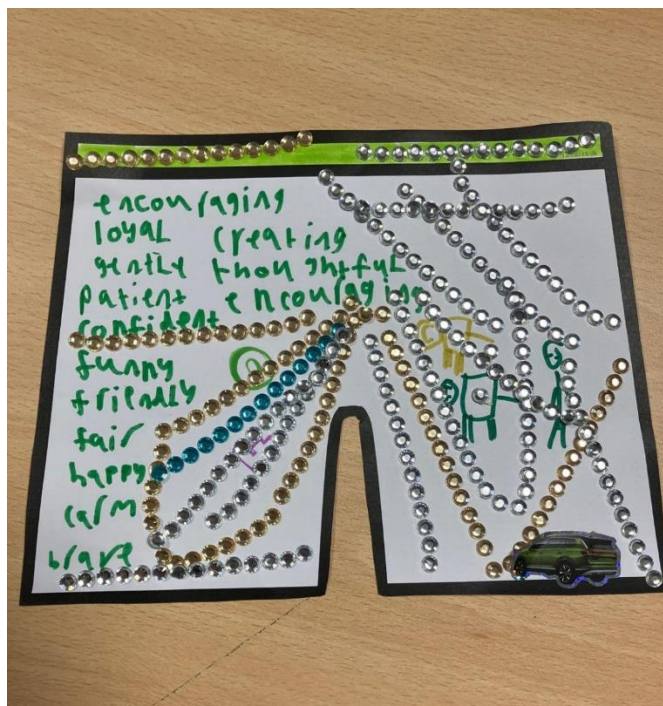


Photo 7. CYP artwork during the development of emotional coping strategies

Data from the parents' interviews repeatedly link such events to practical worker interventions (discussion in advance, reassurance at the doorway, liaison with teachers) and to the young person using coping strategies learned in sessions.

The data suggested an awareness of adaptability: when homework or task sheets felt overwhelming, they were renegotiated or scaled down; when sessions felt too long, workers shortened them and preserved the relational connection. Flexibility was important because it prevented the intervention itself from becoming another source of stress. The co-construction model therefore produced both internal regulation (breathing, reframing) and external scaffolds (passes, adjusted expectations) that together supported participation.

Behavioural and Functional Change: Re-engagement with School and Daily Life

The data revealed positive shifts in day-to-day functioning that parents and young people credited to the LINK support that they had received. This included fewer morning panic episodes, reduced physiological symptoms on school mornings, increased lesson attendance, and willingness to attempt community activities. These changes were often described as incremental, "small steps". Parents emphasised their

real-world significance: attending a practical lesson without anxiety, staying in class for most of the day, or taking part in a community events.

LINK service worker liaison with teachers emerged as a crucial facilitator: negotiating a short pathway into difficult lessons, or temporarily adjusting class routines, reduced the mismatch between the young person's ability to cope and the school's expectations. Several young people highlighted that these behavioural shifts produced emotional improvement such as successfully completing a full lesson produced visible pride and "happy" arrivals home.

"The support I've had has been really good and I would highly recommend it for people who struggle like me because it's helped me come so far in such a short amount of time. Literally in the space of September, October, November, December, five months, and I'm already getting back on my feet, even if it is in slow small parts. It has really been helpful and it's restoring all my confidence one bit at a time. I would really recommend it because it's been so great for me."
Young person 1, age 13

Across the data, a consistent pattern emerged in which young people who had previously responded to challenges with avoidance or crisis behaviours showed measurable improvements in both functioning and mood. Parents frequently highlighted the contrast between the rapid, local access to the LINK service and the lengthy waiting times for statutory services, describing the service's timeliness as a key factor in preventing escalation and enabling early, sustained progress.

Importantly, functional, and behavioural improvements were achieved with a low rate of drop-out or disengagement from the service. Parents and practitioners consistently reported that most children and young people remained actively involved with LINK over time, even when progress was slow or setbacks occurred. This sustained engagement was attributed to the service's flexible, relationship-based approach, which prioritised trust, and responsiveness to individual needs.

Identity, Confidence and Future Orientation: Restoring 'Spark' and Agency

In addition to symptom change, analysis of the data revealed expressions used by young people who talked of "getting my spark back," "feeling open to new things", or having plans for prom, exams in separate rooms and volunteering pathways. These expressions show a shift in temporality and agency from managing the immediate threat of leaving the house to envisaging future steps, education routes, and vocational activities. LINK service workers supported this process by combining reflective listening with small mastery experiences. The mechanism was cumulative: relational

containment and successful micro-experiences equalled newly accessible self-narratives and willingness to plan and take further steps. Importantly, the data indicated that young people internalised explanatory frameworks (e.g., “window of tolerance”, factual/opinion distinctions) which allowed them to reappraise anxious interpretations and reduce catastrophising.

"Yeah, my goal from the start was to just get my spark back and that's exactly what I got." Young person 6, age 13

The data showed that as confidence and functional participation increased, young people began to imagine near-term futures (courses, prom, exams) and medium-term vocational steps.

Family Systems, Access, and Scalability

LINK service outcomes were experienced beyond the individual as parents reported calmer households, different parental questioning styles, and increased capacity to negotiate with schools.

"We've always been close but since [LINK service worker] has come along, I think we've all looked within ourselves... I think we've just all been a bit more tolerant of each other" Parent 13

LINK service workers often acted as translators between home and school, informing teachers of sensory needs and negotiating adjustments, which increased the intervention's impact. Families repeatedly praised the programme's rapid access (weeks rather than many months) and the worker's ability to stabilise crises.

"It seemed to be really fast and that's all I think's been amazing, from saying help, to it coming through to one of the Barnardo's workers. For them to contact us and do an interview with me, it's just been really smooth. And then they have been able to see my son from the start of this year and it's yeah, it's been really, positive." Parent 14

However, some parents identified constraints within delivery. A small number found it difficult to attend additional LINK sessions due to travel distance or cost, particularly for lower-income households. In a few cases, parents and young people reflected that the “match” between the LINK service worker and the child did not fully fit, for example, differences in communication style, personality, or approach that limited engagement. While these instances were infrequent, they highlight the importance of relational fit and flexibility in worker allocation, given the centrality of trust and rapport to the LINK model's effectiveness.

How Sustainable are the Changes Experienced by Children, Young People, and their Families?

Although LINK service workers encouraged and promote independence, a key finding across all data identified that young people thought the conclusion of the LINK sessions felt unusual. In some cases, this was because the strong relationship they had built with their LINK service worker had come to an end. They further described that the strategies learned, and the positive changes made during the LINK intervention were carried forward into the weeks and months that followed.

"It was okay, it was a bit weird to not have them anymore because it was like it was a thing that I got into then and, yeah, it helped a lot, so it was a bit weird going out of it, but yeah." Young person 2, age 15

Young people described how they were able to continue to use the specific techniques once they had been 'discharged' from the LINK service. For example, some young people stated that the strategies they had been taught during LINK sessions continued to be used, particularly in the period immediately after the intervention ended. This reflects the ongoing use of cognitive tools, suggesting skills were embedded and accessible by the YP when required. Other young people described practising skills until they could use them independently.

Indicators of continued impact such as engagement with school and leaving the house, were also cited as evidence of sustained improvements. These practical, real-life outcomes suggest that gains were not only felt emotionally but were enacted behaviourally.

Participants also reported that the service acted as a catalyst for ongoing confidence building that extended beyond the intervention period.

"I feel like I'm still getting more confident and the programme just, like, kick-started the building of confidence itself." Young person 8, age 12

While most evidence relates to short-to-medium term sustainability, several accounts suggest the possibility of longer-term impact. Some young people described that the skills acquired were becoming less necessary over time because difficulties had reduced and coping had improved.

Parents also acknowledged that improvements were sometimes difficult to disentangle from contextual changes (such as moving school forms or developing new peer

groups). However, they linked the intervention to a foundation of skills and confidence that could help sustain positive improvements in happiness over time.

"Well I suppose we were both, me and dad were, I think we were quite happy that you felt happier but because you'd [child] moved forms as well so you'd started in a new form with friends that you knew anyway, it's quite tricky to unpick whether it was moving forms that was the best thing that was happening or it was [Barnardo's] interventions." Parent 4

This highlights the complex; real-world factors associated with sustainability. However, the analysis highlights tentative evidence that the LINK service acted as a catalyst for improvement that was then reinforced by environmental factors, creating conditions for medium-to-long term change.

Mechanisms Influencing the Ongoing use of Supportive Tools.

The data revealed several mechanisms that enabled CYP to continue applying the learning and coping strategies developed through the LINK service.

The first was the continued and repeated practice of cognitive strategies used by CYP in everyday settings.

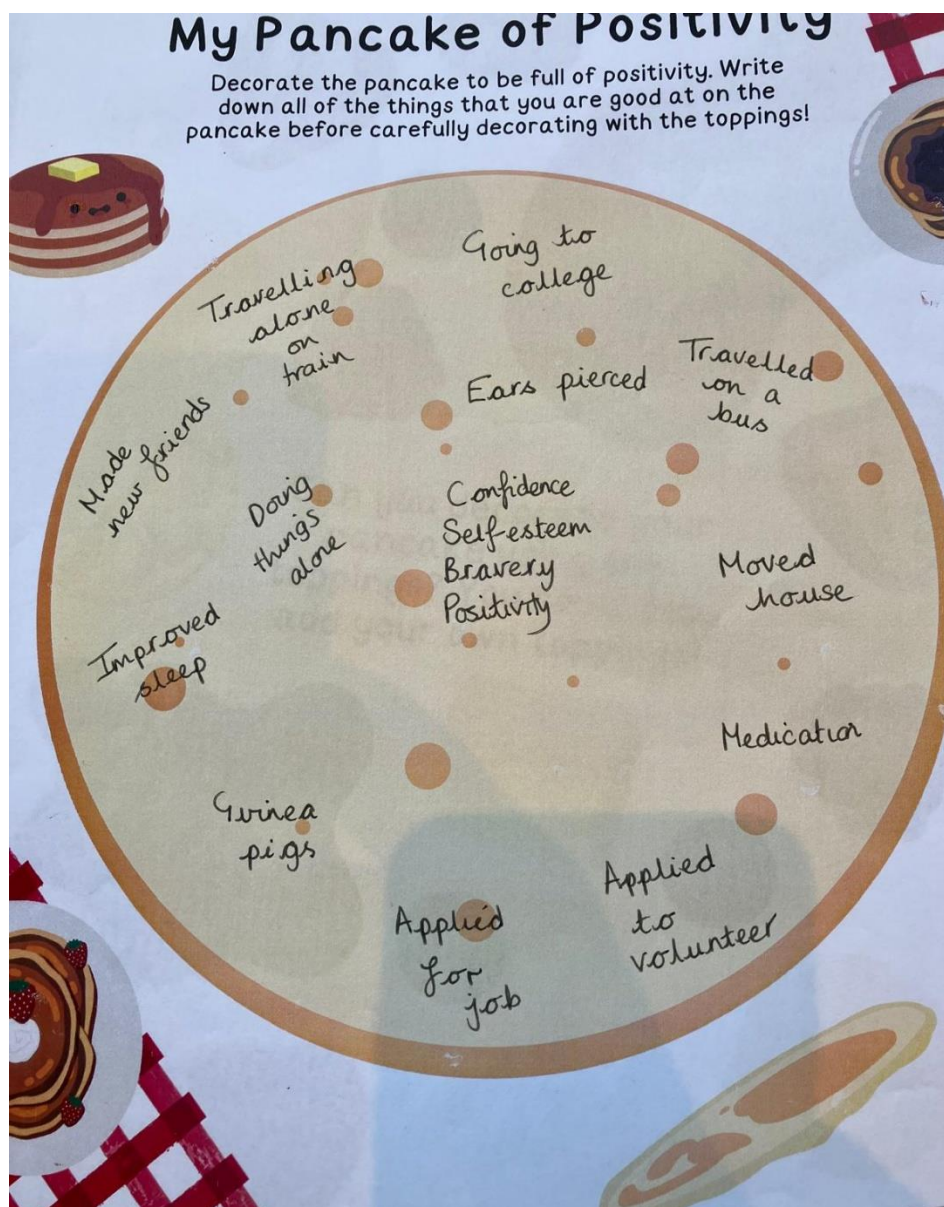


Photo 8. CYP artwork during the learning of coping strategies

Young people described skills which they then applied independently outside formal sessions with the LINK service worker, strengthening their ability to make improvements after the intervention had concluded.

"So, we were like, we sometimes talked about like certain stuff like that so like one session we might be like talking about that and like we'll be like focusing on that and then we'll just carry on doing that until like I can try and use that skill." Young person 5, age 12

The second mechanism was relational support and the experience of being listened to and feeling "seen" by the LINK service worker. Young people described these interactions as a catalyst for long-lasting changes in self-perception and confidence,

which lasted beyond the sessions. Parents also emphasised that this supportive relational environment reduced behavioural expressions of distress at home and promoted calmer interactions.

[When asked if her child uses the coping skills, he has learnt with his LINK service worker elsewhere] " Yeah. And he talks with his sister about them as well. So, the things that he makes with [LINK service worker], he brings home and then we can use them at home. So yeah, no, really positive." Parent 5

By enabling children to externalise concerns constructively during LINK sessions, families reported an indirect but sustained improvement in communication. This highlights the broader relational mechanism by which sustainability was achieved.

The Coordination-Only Offer

The coordination-only strand of the Barnardo's LINK service represents a distinct model within Cumbria's early help landscape. It was developed to provide relational and practical support for families who are often navigating multiple agencies and facing long waits for statutory intervention. This pathway focuses on coordination rather than direct therapeutic work with CYP and mirrors the traditional notion of 'social prescribing.' The steps involved in the coordination process are summarised in Figure 24, which illustrates the referral, assessment, planning, and signposting stages of the offer.

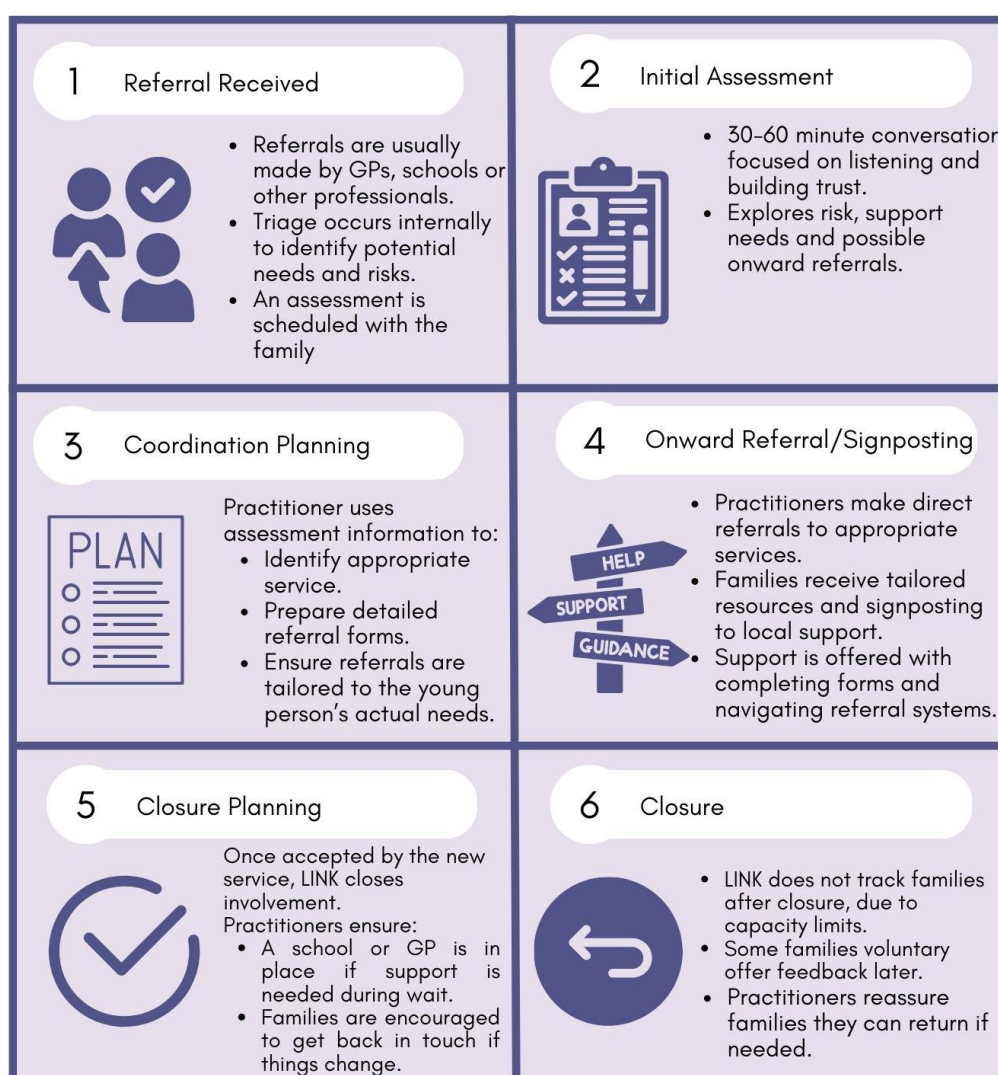


Figure 24. Coordination pathway

It should be noted that CYP have limited direct contact with the LINK service through the coordination-only offer. In most cases, their involvement is restricted to an initial phone call or an assessment to determine the most appropriate pathway. Families are then referred to other services for ongoing support. Consequently, the evidence presented in this section is drawn primarily from parent interviews and staff focus group data. The absence of direct CYP voice reflects the nature of the model rather than a gap in engagement.

The coordination-only role was designed to bring time, clarity, and compassion to families who often reach the LINK service at the point of exhaustion after long periods of navigating fragmented systems. Unlike the core therapeutic pathway, this strand does not deliver regular sessions with CYP. Instead, coordinators complete an initial assessment which captures the CYP's voice, provide tailored signposting and advice, liaise with partner agencies, and ensure that families are connected to the most appropriate sources of support.

Flexibility

Practitioners described the flexibility of this model as both a strength and a challenge. Its adaptability allows the service to respond to diverse and complex needs, yet the lack of a fixed structure can make the role harder to define for families and partners. As one practitioner explained:

"It's quite hard to describe really because there's so many different things that we do as coordinators. And it's not just one specific thing."
LINK service workers member.

This flexibility enabled LINK service workers to tailor their work to each family's needs, whether liaising with schools, contacting GPs, assessing risk, making onwards referrals to specialist support, or simply listening. However, there was some confusion about the boundaries of the role, for example one family felt that the coordinator may have followed up with the outcomes of CAMHS referrals. Families, meanwhile, often described this flexibility as a lifeline. For many, the LINK service worker became the first professional to take ownership of their situation, offering a sense of movement and hope after prolonged stagnation in statutory pathways. One parent explained,

"It's really, really overwhelming. It really is. So to have somebody say, right, you know, the lady on the phone, she really listened to exactly what I was saying and what the problems are and I think she then recommended some things, but then she went away to management teams and then they had a discussion and she came back with this list of services that they felt would be the most beneficial. That in itself, like somebody telling me, go to these ones, that was amazing."
Parent 7

This balance, between professional flexibility and family reassurance, appeared to define the coordination-only role, which seemed to function as a bridge, offering light touch but meaningful intervention that connects families to appropriate help while restoring their confidence that the system can respond.

Relational Practice and Emotional Support

Central to the coordination role was relational and emotional support such as LINK service workers taking the time to listen, understand, and respond with empathy rather than urgency. Practitioners highlighted how this non-clinical, unhurried engagement allowed children and parents to open up without fear of judgement. As one coordinator described:

“We’ve got the time to listen to you. We do actually, genuinely care. And we’re not waiting. We haven’t got another appointment booked in 10 minutes after this. So, we’re not rushing you out the door. We’re not in a clinical environment. We’re not in a hospital or a doctor’s surgery. We’re relating to you.” LINK service worker 2

Parents also confirmed this:

“[LINK service worker] that I spoke to, she used to sometimes ring me, and I’d just burst into tears, and she would sit for an hour on the phone, until I’d calmed down and talk me through things.” Parent 1

These exchanges demonstrate how the emotional presence and active listening of the LINK service worker operated as therapeutic mechanisms. Even brief interactions had emotional impact, parents described feeling lighter, calmer, and more hopeful after calls or meetings. For many, this was the first professional space in which their distress was met with empathy rather than dismissal.

Navigating Systems and Managing Barriers

The coordination offer’s strength was that it helped families navigate complex and often disjointed systems. Coordinators saw themselves not just as sign-posters but as advocates who took responsibility for ensuring families reached the right support.

“I think that also makes [us] a bit different than other services, that we don’t just get a referral in and just pass it on. We actually make sure that we’re getting the right information.” LINK service worker.

Parents repeatedly confirmed how valuable this was:

“They got in touch with my GP for me, they got in touch with the school, they initiate- so they signposted me to other advisory

services, such as the [local service], in West Cumbria, that helps people, like helps families with anyone with neurodiverse problems really. So, they signposted me to lots of different places.” Parent 1

Other parents described the LINK service as the first service that ‘did something’ rather than passing them on or leaving them to chase responses.

However, both groups (parents and practitioners) recognised that systemic barriers, particularly long waiting lists for the services that CYP had been referred to by LINK service workers as well as patchy provision between areas. Both of these factors undermined progress. One staff member described:

“Some services you might have like an 18-month wait list for. So, it’s really tricky.” LINK service worker 2

In this context, the coordination role often became a holding space, stabilising families while they wait for others to act. Practitioners described this as emotionally demanding but essential, as it prevents families from disengaging altogether.

Communication and Clarity of Offer

The analysis of the data sets highlighted that both parents and staff identified a persistent challenge when explaining what coordination-only support involves. Parents often arrived expecting therapeutic work, sometimes based on what they had heard from schools or friends.

“People hear like, ‘oh, my friend went through LINK, and she got one-to-one for her son at the school.’ And I thought I would get that kind of thing.” LINK service worker 3

Parents described their confusion:

“I thought that [my child] would get some therapy sessions, some therapeutic sessions... I thought, oh, this is a service for one to one and that’s it. I didn’t actually think that there was any other outcome with the terms of service.” Parent 7

This mismatch occasionally led to disappointment; despite the quality of support, they received.

Practitioners responded by investing time at first contact to clarify the purpose of coordination:

“I always try and have a conversation with them that first time, whether that’s face to face or over the phone and explain that this

is your chance to tell me everything. So, we can make sure your child, or the young person is going to get the most appropriate support. And I say like we do offer one to one, but we also coordinate for the services.” LINK service worker 1

Some staff repeated explanations at the end of calls to reconfirm next steps and manage expectations.

Indicators of Impact

Despite some confusion about what the coordination role of the LINK service offered, families and referrers described the coordination offer as transformative. The immediate benefit was emotional, the relief of finally being heard, but the practical benefits were equally significant. Coordinators produced high-quality referrals, comprehensive summaries, and clear onward plans. One staff member explained:

“We are both getting them to the place where they need or want to be ultimately, but also they’re having an experience of a positive relationship with the professional.” LINK service workers 2

Parents described this in tangible terms:

“So, she then referred her to CAMHS and CAMHS have actually accepted it.” Parent 4

These examples illustrate how coordination-only work could create momentum even within constrained systems. By blending relational warmth with procedural clarity, LINK service workers helped families shift from paralysis to progress, often marking the first successful referral after years of rejection.

Taken together, these accounts reveal how the coordination-only offer creates change through three interrelated mechanisms: relational depth and containment, system navigation and advocacy, and continuity and empowerment. These mechanisms are illustrated in Figure 25.

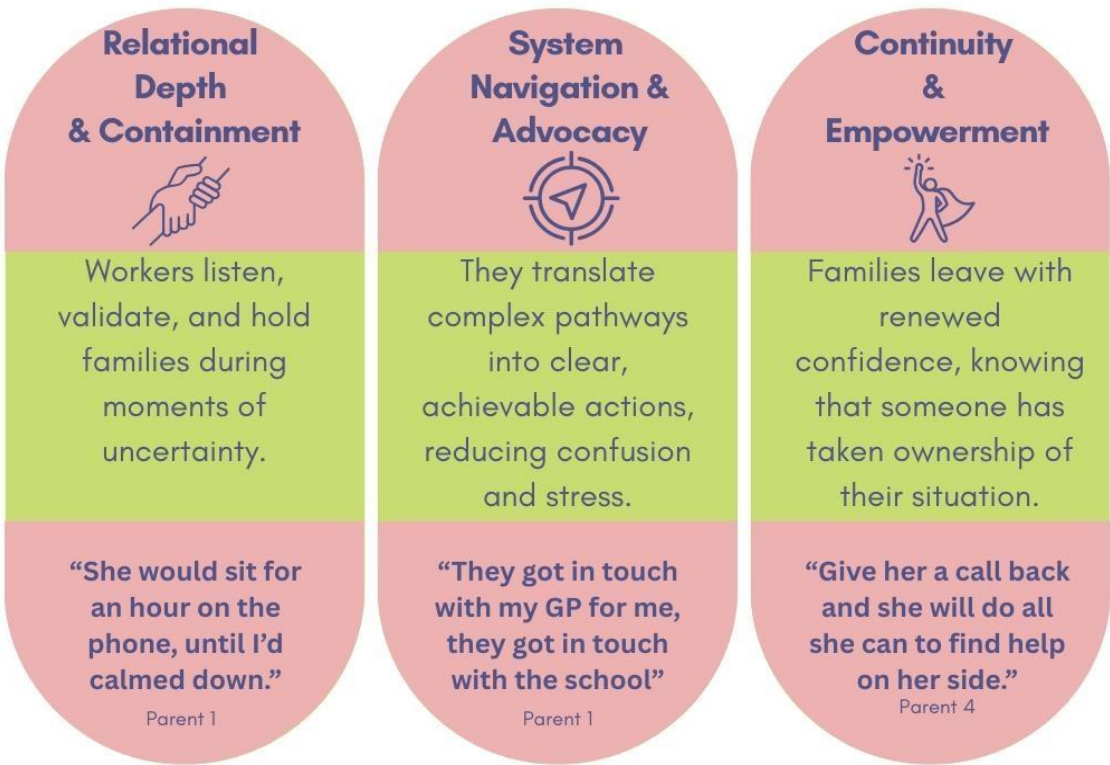


Figure 25. Mechanisms of impact

Challenges and Future Development

Practitioners reflected that although flexible, the coordination offer creates challenges of definition and consistency. Without a single framework for describing the coordination pathway, both referrers and families sometimes approach it with mismatched expectations. LINK service workers emphasised the need for consistent public messaging and accessible, plain-language materials that outline what the role entails.

Parents, meanwhile, highlighted the importance of continuity.

"He seemed to be doing quite well with the sessions, and then it changed to another lady which obviously just threw him a bit. He was a bit kind of, I don't know what to do now. So, he kind of shut down a bit with her." Parent 3

Such changes, while inevitable in new interventions, could risk undermining the trust and momentum that are central to the coordination model's impact.

Families and staff spoke about the emotional intensity of the role. Hearing distressing stories in short bursts, without extended involvement, can be difficult for practitioners.

Protected supervision and reflective spaces were described as essential for maintaining emotional resilience and service quality. Several staff suggested introducing light-touch follow-up, for instance, a short text or call after three months, to check progress and offer reassurance, which could help sustain engagement and evidence long-term value.

A further challenge identified by parents related to follow-up and the burden of the next steps for the YP and family. While LINK service workers provided clear advice and tailored referrals, families often felt that the responsibility for acting on these fell solely to them.

“I think she's told me but I'm sort of overwhelmed with bits of information at the moment. There's just a lot going on and I don't know which services are which, to be honest, with various different referrals. She definitely told me.” Parent 6

For some parents, the emotional relief of being listened to was not matched by practical follow-through. This is not a reflection of LINK service worker performance but a structural feature of the model, once signposting is complete, support ends. For families managing high stress, neurodivergence, or isolation, this expectation of self-navigation can stall progress. Practitioners and parents alike suggested that a brief check-in or lighter-touch follow-up could help bridge this gap and sustain momentum after closure.

Summary and Reflections about the Coordination Role

The coordination-only offer within Barnardo's LINK service demonstrates how relational listening, compassion, and pragmatic system navigation can produce meaningful outcomes for families in distress. The data show that even light-touch support can generate a sense of stability and direction when families are struggling with fragmented or unresponsive systems. The model's strength lies in its ability to combine relational depth with procedural clarity workers build trust while taking practical steps that move families closer to the right help.

The analysis highlighted three interlinked mechanisms underpinning this impact: relational depth and containment, system navigation and advocacy, and continuity and empowerment. Together, these elements create a service that supports families safely during moments of uncertainty, translates complexity into manageable actions, and restores confidence that the system can respond.

At the same time, the coordination model brings structural and emotional challenges. Its flexible and adaptive nature allows LINK service workers to respond creatively to local need, but this same fluidity can create role ambiguity for families and professionals. Staff described the emotional intensity of working with families in

distress over short periods and emphasised the importance of supervision and reflective space to maintain wellbeing and service quality.

Looking ahead, the evaluation findings indicate that clearer public messaging, accessible written materials, and a brief follow-up mechanism could strengthen both understanding and continuity. By embedding these refinements, the coordination offer could provide an even more robust and sustainable early-help layer within Cumbria's system of care—one that complements therapeutic work while ensuring no family is left without support or direction.

What is the Impact of the LINK Service at a Community and Service Level?

The LINK service has established itself as a key point of connection between children, families, schools, primary care, and specialist services, achieving a level of community integration that positions it as both accessible and highly valued within the wider system. Across interviews with staff and referrers, the LINK service is consistently described as embedded within local pathways, with practitioners highlighting that it has become a “first port of call” when concerns arise. This speaks to a level of trust and familiarity that has grown over time, reflecting the programme's responsiveness and consistency. Rather than existing in isolation, the LINK service operates in close dialogue with schools, general practitioners, social prescribers, and CAMHS, ensuring that CYP are not left unsupported while waiting for higher-tier services. This dynamic has been recognised by the health system as an important safety net, providing reassurance to professionals who are often left with limited options when immediate support is required.

Schools in particular appear to have integrated the LINK service into their everyday practices, regularly turning to the service not only for support with individual children but also for its contribution to broader wellbeing agendas. This integration was supported by the LINK service's regular and predictable presence within school settings, with schools working with named LINK service workers and engaging through routine, ongoing contact rather than ad hoc referrals. The LINK service also delivers assemblies and awareness-raising activity within schools, increasing visibility of the service and supporting wider understanding of how pupils can access support. Teachers and pastoral staff describe the LINK service as a dependable partner that mirrors their priorities, such as keeping pupils in school and maintaining attendance, while also offering a bridge to more specialist input where required. This sense of shared ownership is deepened by the LINK service's consistent communication, with schools emphasising how they always “know exactly where they are” with the service and how the LINK service keeps them informed of progress. In practice this includes timely confirmation of referrals, clarity about next steps and timescales, and regular updates that allow schools to track progress and plan around support. This transparent

and reliable approach has allowed the LINK service to become a natural extension of school-based provision, creating a collaborative rather than transactional relationship.

Healthcare professionals and social prescribers also view the LINK service as a complementary layer of provision within the wider system. Several accounts highlight how the programme fills a critical gap between primary care and CAMHS, offering a viable and immediate option for children who do not meet thresholds for specialist intervention but still require timely support.

“It's bridging the gaps in services, for the young people, especially the ones that are isolated.” Senior practitioner in local authority

This positioning has been welcomed by the health system, which recognises that the LINK service both alleviates pressure on overstretched services and ensures that families are not left without direction. Staff within the LINK service also describe how the team has forged strong links with other local services, signposting when needs fall outside their remit and collaborating to ensure that young people are supported at the right level. The ability to flexibly operate at this interface has been crucial in building credibility with health colleagues, who view the LINK service as a trusted partner capable of both delivering meaningful support and coordinating care across boundaries.

Importantly, integration of the LINK service has not only occurred at the level of professional practice but also in the broader perception of the LINK service as part of the local ecosystem. Referrers consistently describe the programme as a “support mechanism” for the community, offering hope and reassurance during times when statutory services may feel distant or inaccessible. This reputational standing has contributed to the LINK service being firmly “received” by the system as a valued partner rather than a peripheral or temporary initiative.

“I think not being in silos but seeing as navigation. We're all part of the triage now with targeted and specialist... And that has been working so well because we know who's referred to who, and we're also making the GPs and the schools be clear that it's one referral and that referral will get to the right place because we're all in the same table together.” LINK service manager.

The programme's structured yet adaptable model has reinforced this acceptance, demonstrating to health and community organisations alike that it can operate sustainably, meet demand, and adapt to shifting local contexts. Taken together, these perspectives reveal that the LINK service has achieved more than operational collaboration: it has become integrated into the culture of local practice, trusted by schools, health professionals, and wider community partners as an essential element of the prevention and early help landscape.

Case Studies/ Vignettes (CYP/Parents with Multiple Timepoints)

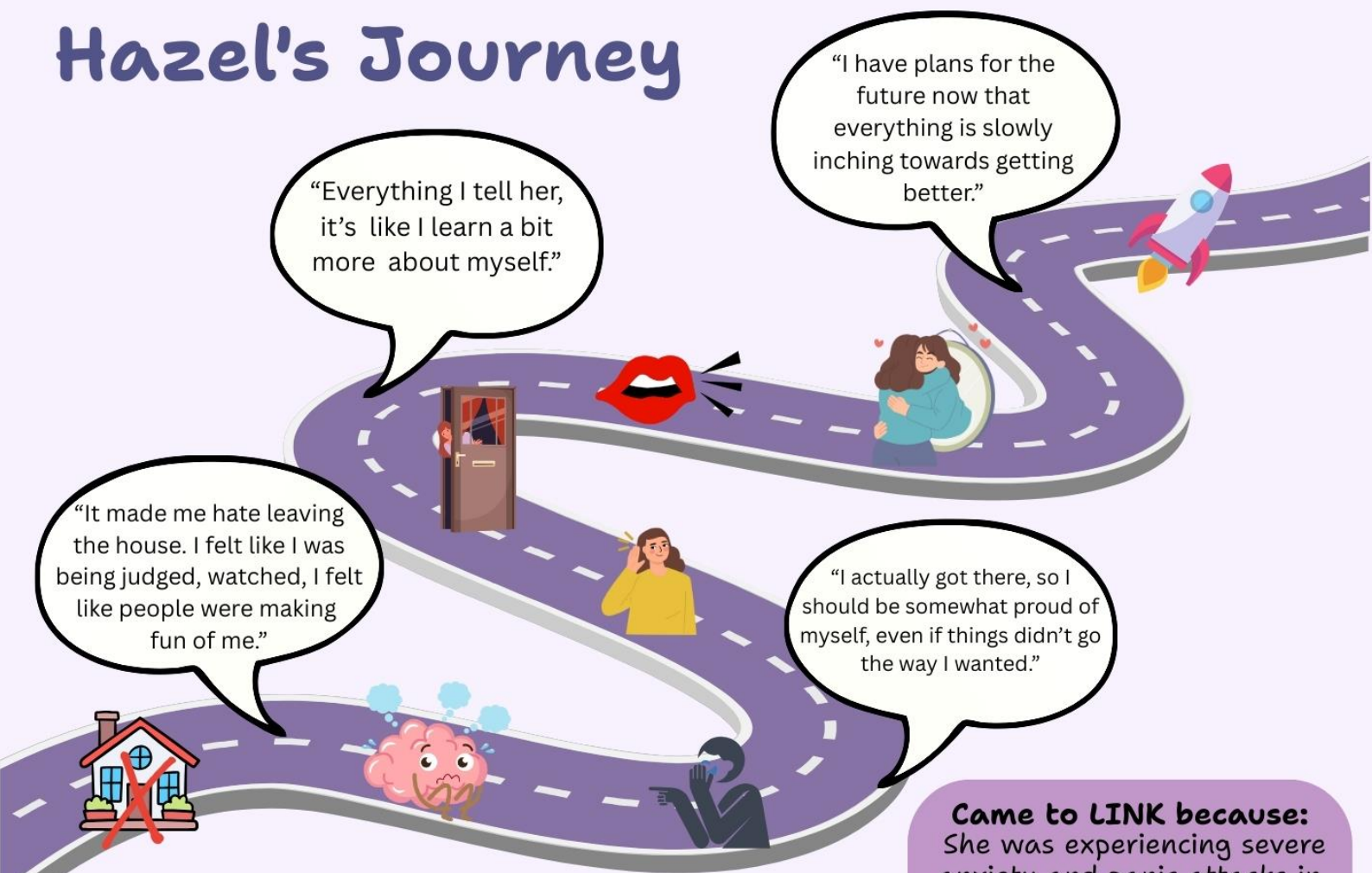
As part of the evaluation, five young people and their families were interviewed over a period in their journey. This provided longitudinal data which enabled an opportunity to build up case studies that trace experiences over time. For ease of presentation, interviews have been grouped into timepoints.

It is important to note that the timepoints do not always reflect a chronological sequence through the LINK journey. In some cases, a participant's "Timepoint 1" interview took place well into their sessions, simply because earlier opportunities for interview were not possible. As such, the timepoints should be read as markers of when data was collected, rather than fixed stages of the programme.

The case studies are designed to highlight individual journeys, showing how young people and families experienced the LINK service in their own words. They are not intended to be representative of all participants, but they provide rich, illustrative examples of change, continuity, and the ways in which the service has impacted young people's confidence, relationships, and wellbeing.

Pseudonyms have been used throughout the case studies to protect the anonymity of participants and ensure that individual young people and families cannot be identified.

Hazel's Journey



"Everything I tell her, it's like I learn a bit more about myself."

"I have plans for the future now that everything is slowly inching towards getting better."

"It made me hate leaving the house. I felt like I was being judged, watched, I felt like people were making fun of me."

"I actually got there, so I should be somewhat proud of myself, even if things didn't go the way I wanted."

Came to LINK because:
She was experiencing severe anxiety and panic attacks in public places, which left her unable to leave the house over the summer.

Hazel is a young person with a strong passion for art, drawing, and painting. When she first engaged with the LINK service, she had been experiencing severe anxiety that left her unable to participate in public activities, go shopping, or enjoy social events with friends. Her journey with the LINK worker charts a gradual but significant rebuilding of confidence, self-understanding, and hope for the future.



In her first interview (week 3)

Hazel described being very nervous to meet her LINK worker but quickly felt at ease due to her "very friendly presence" and calming aura. Early sessions focused on talking, reflection, and initial strategies for handling anxiety. She recalled panic attacks in crowded places such as the local town and the airport, which had left her fearful of leaving the house.



Small first steps were already emerging. She managed a brief visit to a shop, bought a pumpkin, and even hosted a dinner for friends, though she had to leave when panic set in. With her LINK worker's support, she reframed this not as failure but as progress: "I actually got there, so I should be somewhat proud of myself, even if things didn't go the way I wanted." She hoped to regain confidence, "make up for lost time," and eventually return to everyday activities like eating out and visiting places with friends.



By her second interview (week 7)

Hazel's progress was more visible. Completing an autism referral form with her LINK worker helped her "learn a bit more about myself," and she began taking cautious steps outside, such as quiet evening trips to shops. Her mother recognised these as "big steps."

OPINIONS

FACTS

She also started using coping strategies, particularly distinguishing between "fact or opinions." For example, she worried about a friend not replying to a message but later realised her negative thoughts were only opinions, not facts.

Hazel described her relationship with her LINK worker as going "very, very well," saying she felt free to be herself and able to discuss personal feelings without fear of judgment. Her next goal was to try short walks with her LINK worker and eventually reach a nearby bench, while also looking ahead to bigger milestones such as the cinema and Christmas activities.

In her final interview (week 12)

Hazel's transformation was striking. She represented her journey through artwork showing three figures: one in a darkroom symbolising isolation, one reaching for the door as she attempted to leave the house, and one standing outside, symbolising her hope to be free from anxiety. She described the door as both literal (going out) and symbolic (escaping dark thoughts).

She emphasised the impact of her Link worker: "Ever since the start, she's listened to me... and then we started going out for walks. Every time I see another person, it feels like I'm gaining my confidence back in small chunks." She had also adopted practical strategies, such as reframing unhelpful thoughts, which gave her motivation and made her feel "a lot happier now."



'From a Mum's point of view, we feel like we've finally got somebody to turn to, to talk to and finally getting some help'
- Hazel's Mum

She was preparing to re-enter school for exams, excited about prom, and looking forward to a friend's birthday sleepover. As she put it: "I'm open to exploring new things now. I have plans for the future now that everything is slowly inching towards getting better." Hazel described the LINK service as "really, really good" and said she would recommend it to others: "It's restoring all my confidence one bit at a time." She felt her LINK worker made her feel "seen and heard... in a way that I know things will get better."

Closing Reflection

Hazel's experience shows how a safe, trusting relationship could enable young people to rebuild confidence. The service met her expectation of gaining support to re-engage with everyday activities, helping her feel listened to, valued, and respected. Over time, she moved from isolation and anxiety to re-entering school, reconnecting socially, and planning for the future. Her mother also observed clear improvements, highlighting the wider family impact.

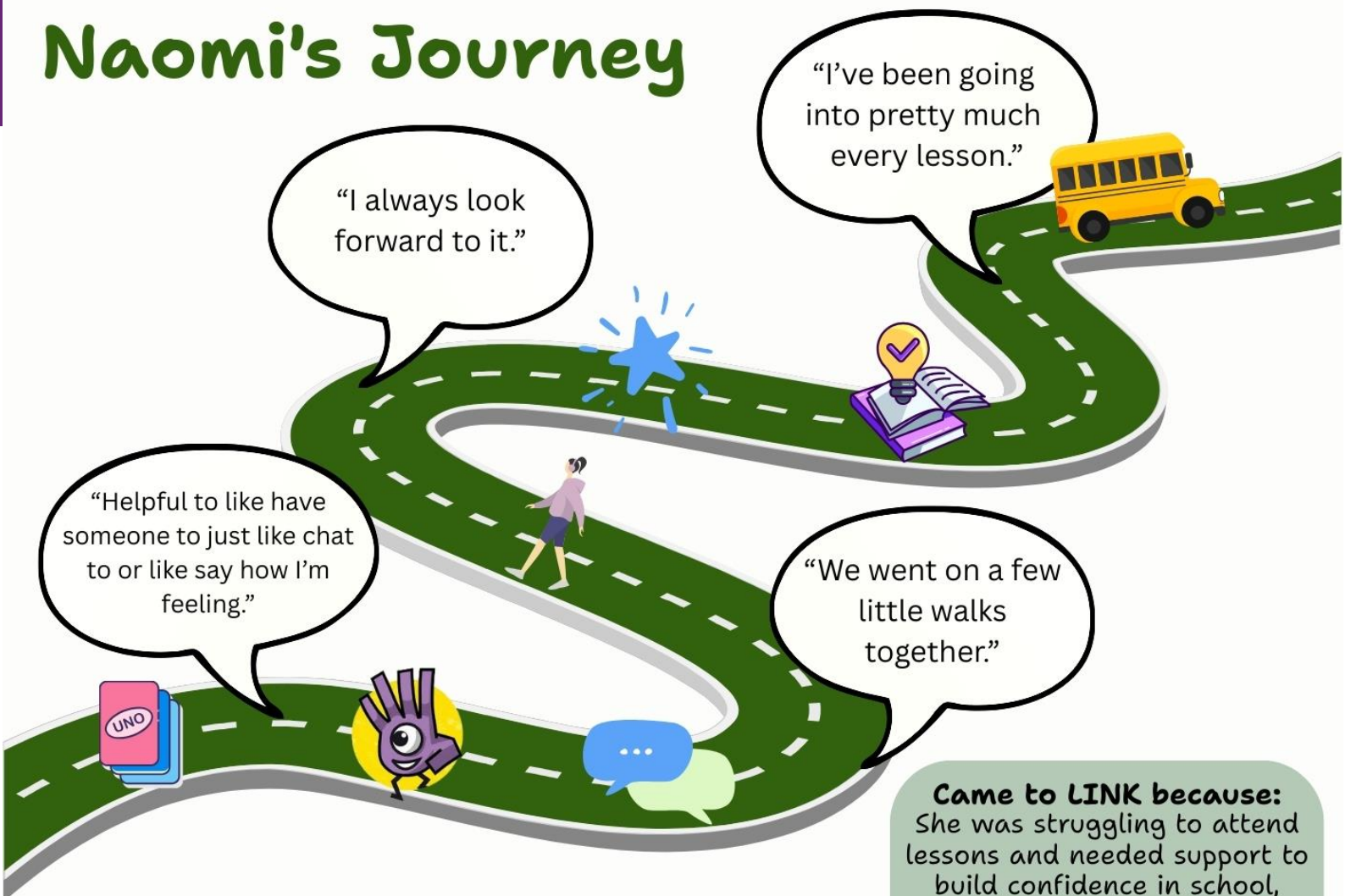


“Yeah, that's basically, it's like three little people, but it's like where I was before I met [LINK Worker], where I'm heading and where I hope to be in the future. So it's like the darkroom kind of represents all my thoughts and the fact that I kind of spiralled and wasn't able to leave the house and then the door is me.

Yeah, whenever I left the house I felt like everyone would stare at me and it made me feel horrible. And then the door, that's kind of like my way to getting out the house, or ... how do I put this? It's like, I can actually leave the house and go places, but I'm also leaving that darkroom and like leaving all those thoughts behind. And then the third one is where I hope to be out in the open, back to my old life, seeing my friends again, just with all those negative thoughts gone.”



Naomi's Journey



Naomi is a dedicated dancer who performs in summer and Christmas shows and takes graded exams. She first connected with the LINK service in Year 7 to build confidence around school and lessons, continuing into early Year 8. Sessions typically mixed gentle conversation, simple games, and practical planning around her timetable.



"It helps me to like sometimes if maybe I'm having a hard day or something, just to come once a week and just like have like kind of a quiet, but talking time."

Naomi



In her first interview (week 3)

Naomi described the early sessions as helpful to "have someone to just like chat to or like say how I'm feeling," often while playing card games or walking through her upcoming lessons. She appreciated having real choice: the Link worker "recommended what we could do in the sessions and I... picked out the different things," with the aim of becoming "more confident" in lessons and "believing in myself a bit more."



By her second interview (week 10)

Over the summer and into Year 8, support included weekly or fortnightly meet-ups, short walks, and a visit to an animal charity. Naomi enjoyed "being the leader a little bit," showing the LINK worker around her village, which made the sessions relaxed but purposeful. Confidence around lessons had grown: "over the last... two weeks, I've been going into pretty much every lesson," supported by a trusted adult in school and the steady, conversational style of sessions.



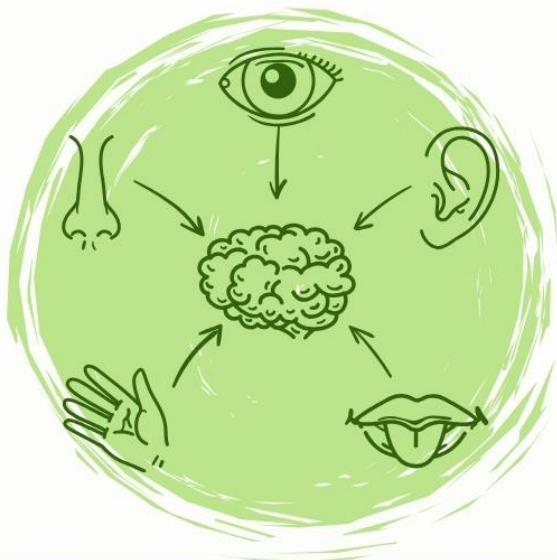
Weekly check-ins with low-pressure games gave her a "break from the busyness of school" while keeping her "brain working." The approach was flexible, with plans to continue only if needed.

In her final interview (3 months later)

Several months after support ended, Naomi reported that progress had stuck: she was attending "pretty much every day unless I was ill," taking the bus twice a week, and joining most lessons daily, now her normal routine. She said the LINK support had helped make that shift. Grounding tools such as the 5-4-3-2-1 senses check were useful immediately after sessions ended and remained part of her repertoire.

"We were really appreciative of it really, and that it was free as well which is fantastic. Yeah, it was just really good, and like I say, the match between you and [Link Worker] was perfect, wasn't it?"

Naomi's Mum

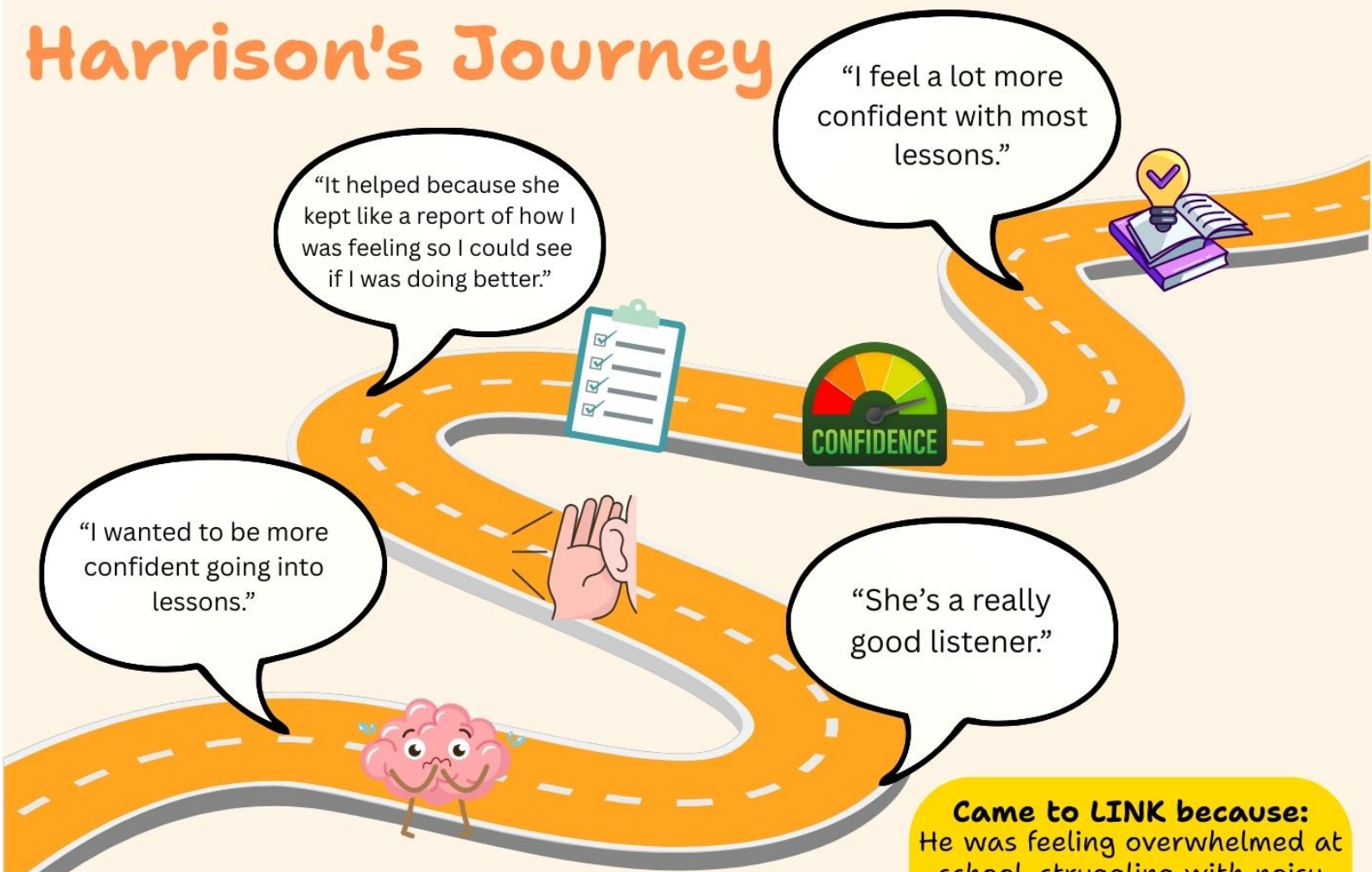


School-based provision mirrored Naomi's positive experience of LINK, offering a calm space, friendly staff, occasional games, and a conversational approach that suited her. In hindsight, Naomi felt the support had the "right variety" and helped her achieve her goals. Although she would have welcomed support continuing slightly longer into Year 8, she was satisfied with how the transition was managed.

Closing Reflection

Naomi's case shows how the LINK service built confidence through flexible, relationship-based support. She valued choice, relaxed sessions, and conversational approaches that made her feel safe and respected. The service met her expectations, helped her achieve personal goals such as attending lessons more regularly, and gave her lasting tools to manage challenges.

Harrison's Journey



Harrison was referred to the LINK service by his school at the start of 2025 after struggling with anxiety around lessons and sensory challenges. He hoped the support would help him feel more confident attending lessons and managing school life.

Came to LINK because:
He was feeling overwhelmed at school, struggling with noisy lessons and feeling sick and panicky before classes, and needed help to cope and feel more confident.

In his first interview (week 5)



By the time of his first interview, Harrison had already attended five sessions. He described the experience as positive, particularly appreciating how the LINK worker asked clear, direct questions: "Sometimes I feel like I don't really know what to say, but... she asks just like direct questions... so then she knows what to do for next time."



Sessions included check-ins, simple worksheets such as colouring blobs to represent emotions, and open conversation. Harrison valued that the LINK worker was "a really good listener" while also contributing when needed, making sessions supportive rather than pressured. He explained that the service was "just a really nice service where you can just talk to people and say how you feel." Although he sometimes struggled to put feelings into words, the sessions helped him relax and gradually open up. He also appreciated the continuity of support during school holidays, which prevented setbacks.



His parent echoed these positives, noting the unusually fast referral and visible improvements in Harrison's anxiety, especially around food technology. They valued the calm, third-party support of the LINK worker but suggested parents would benefit from occasional updates or shared strategies.

By his second interview (6 weeks after)

By the second interview, Harrison had completed the programme. He said it “helped me with a lot of stuff” and found it strange at first not to have sessions anymore, as they had become part of his routine. Progress was tracked through weekly reports and visual charts, which showed him moving “at the high bit,” reassuring both him and the LINK worker that he was ready to end.



His main goal had been “to be more confident going into lessons and not be worried for... a while before,” and he felt he had achieved it. He now felt “a lot more confident with most lessons,” crediting both the LINK worker’s support and a change of school form that placed him back with familiar friends. Harrison said sessions focused on his priorities: “We sometimes talked about like certain stuff... and then we’d just carry on doing that until I could try and use that skill.” He also noted he continued using strategies after the programme ended.

“As a parent, it’d be it would be good to have a, don’t know, a six weekly meeting. [...] You know, just sharing strategies I think would be useful but without breaking confidence.”

Harrison’s Mum

His parent agreed improvements were clear but felt it was hard to separate the role of the LINK worker from the impact of changing forms. They praised the organisation and communication around session timings but raised a gap: there had been no structured debrief at the end of the programme. They felt more feedback on Harrison’s progress and strategies would have helped the family continue supporting him consistently.



Closing Reflection

Harrison’s case shows how the LINK programme could quickly reduce school-related anxiety and help young people build confidence in lessons. He valued the clear, direct communication of his Link worker and described sessions as a safe space to talk. The programme met his expectations and equipped him with strategies he still uses. His parent also recognised improvements but highlighted the importance of clearer communication with families, particularly at the close of support, to sustain progress.

Lottie's Journey



"The breathing exercises were helpful, but I suppose it's like the amount of sheets because there were quite a lot."

"It feels like too structured in a sense."

"We also did a goal thing... what I said was start to tic less through coping mechanisms. And also sleep more because my sleep habits are awful."

"She's a good listener and it's like it's a relaxed like, nice environment. There's, like a comforting environment."

Came to LINK because:

She was struggling with painful tics, overwhelming anxiety, and difficulty coping at school and at home, including problems with sleep and feeling easily overwhelmed.

Lottie is a creative young person who enjoys art and drama, taking part in a local theatre company outside school. At the point of referral, she was struggling with painful tics, poor sleep, and feeling overwhelmed. The LINK service aimed to help her manage anxiety, develop coping mechanisms, and support her wellbeing in school.



In her first interview (week 5)

Lottie described enjoying her sessions with the LINK worker and feeling comfortable in a "relaxed, nice environment." Sessions typically involved check-ins, weekly goals, and reviews. While she initially liked worksheets and homework, her parent noticed they sometimes triggered anxiety if unfinished.

She felt listened to and able to shape sessions, though her parent felt the approach could be rigid. Lottie wanted "more techniques to help calm me down," aiming to reduce tics, improve sleep, and manage noisy environments. She believed she was "ticcing a wee bit less," though her parent was less certain of progress outside school. The family valued the quick referral and potential for school-based feedback but wanted more direct communication with the LINK worker.



By her second interview

(Lottie had 7 sessions altogether and this interview took place a month after she had finished)

Engagement had become more difficult. Although her tics continued to ease, she and her parent ended sessions earlier than planned as they were causing her significant anxiety. Lottie said she sometimes felt “like I wasn’t being listened to” and found the sessions “too structured,” with worksheets and note-taking adding pressure. Her parent explained that, as someone eager to please, Lottie became distressed when unable to complete tasks, leading to sleepless nights.



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Breathing and grounding exercises were introduced but had limited impact. Both Lottie and her parent felt more creative approaches, such as art therapy, would have been a better fit. Her parent later explored this as an option.

“It’d be nice if we had sessions as well where we could speak and say ‘this is something that’s bothering [Lottie] at this moment in time, she’s getting overwhelmed with this. Is it something you can help?’

- Lottie’s Mum

Her personal circumstances also shaped her experience. Lottie worked hard to keep some aspects of her identity private, even among friends. Her parent reflected that this secrecy, combined with worries about being judged, added to her anxiety and may have made it harder for her to engage fully with the structured approach.

Despite challenges, Lottie stayed socially active, with a strong friendship group and involvement in trips. However, experiences of feeling singled out or separated during school activities underscored the pressures she faced. Her parent also voiced broader concerns about the lack of appropriate support for young people navigating these challenges.



Closing Reflection

Lottie’s case shows how the LINK service can feel supportive and relational, while also highlighting how individual responses to structure can vary significantly. Although most children and young people described the service as flexible, child-led, and responsive to their needs, Lottie experienced the more task-based elements of support as overwhelming. While she initially felt listened to and comfortable, the use of worksheets and goal-setting gradually increased her anxiety and contributed to disengagement.

Her experience does not reflect the typical response to LINK, but instead underscores the importance of continual attunement and adaptability, particularly for young people who are eager to please or who experience anxiety around tasks and expectations. It highlights the value of having a broad toolkit of approaches available, including creative and interest-based methods, so support can be shaped in ways that feel genuinely calming and manageable for each young person.

Lottie’s story also draws attention to how wider identity-related pressures and fears of judgement can compound anxiety and affect engagement. While her family valued the speed of referral and the relational warmth of the LINK worker, they emphasised the importance of clearer communication with parents and ongoing flexibility to help sustain progress over time.

Freya's Journey



Freya is a young person with a strong interest in understanding herself, particularly the "why" behind her emotions and behaviours. She joined the LINK programme seeking clarity about her experiences and strategies to regain her spark and confidence.

In her first interview (week 10)

Freya explained that her main goal was "to kind of understand more of like what was going on in my head rather than how I actually was." The LINK worker often researched topics between sessions and returned with explanations that appealed to Freya's scientific curiosity, making the support feel personalised and engaging.



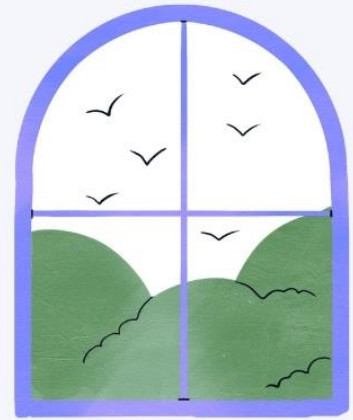
Flexibility was important. Freya valued that sessions did not always have to focus on mental health, sometimes simply chatting about everyday life. She preferred sessions at home, though she did take part in some group outings. Crucially, she felt consistently listened to: "There wasn't any point at all where it remotely felt like I wasn't being listened to."



By this stage she felt "very much almost there," with only some school-related challenges remaining. Progress was tracked with simple feedback scales, which gave her a sense of control. She anticipated only needing "a couple more" sessions. Her parent described the experience as having "absolutely surpassed anything" they had expected and said the LINK worker's style transformed family communication. Both suggested that more family sessions would be valuable, as early joint conversations had already surfaced things previously left unsaid.

By her second interview (4 months after)

Freya had completed the 12-week programme. She reflected that her goal had been “to just get my spark back and that’s exactly what I got.” Tools like the “window of tolerance” stayed with her: “It helps me realise that the reason why I’m, like, crashing out when I feel negative is just because of the window of tolerance getting smaller.”



Smile
WITH
CONFIDENCE

She also gained confidence from group activities, enjoying opportunities to “communicate with a lot of new people.” She felt the programme had kick-started a lasting process: “I feel like I’m still getting more confident and the programme just, like, kick-started the building of confidence itself.”

Her parent emphasised how transformative the 12 weeks had been for the family: “We’ve been struggling for five years, haven’t we, on and off... and it’s made a five-year trek a lot easier.” They said the explanations changed how they communicated with Freya, helping the whole family feel calmer and more united: “Rather than it being three and one, we’ve kind of all come together as four again.”



“I think they could have done with more family sessions or household sessions. That was the only thing, because I only sat in with [Freya] for two sessions right at the beginning. [...] But those two sessions that I sat in were invaluable to me.”

Freya’s Mum

Both Freya and her parent valued the flexibility of the programme, sessions could be shortened if she felt drained, and she was given real control over the content. The main suggestion was for more family sessions to ensure everyone shared the same understanding and tools.

Closing Reflection

Freya’s journey shows how the LINK service could support young people by meeting them where their interests lie. She valued flexibility, clear explanations, and being listened to, all of which helped her regain confidence. The programme met her expectations of “getting her spark back,” and gave her lasting tools to manage challenges. Importantly, her parent also noted wider benefits, with improved family communication and a stronger sense of togetherness.

Case Study Findings

The longitudinal case studies presented above illustrate the depth and variability of individual and family experiences within the LINK service. Taken together, they provide a narrative complement to the thematic findings, showing how the mechanisms identified elsewhere in this report - relational containment, co-constructed skill-building, and gradual re-engagement with school and community life - played out in real contexts over time. Each case traces a distinctive trajectory, reflecting the programme's flexibility and responsiveness to individual need.

Across these accounts, three overarching themes are evident.

1. First, the relational foundation of the LINK service consistently emerged as the catalyst for change. Trust, consistency, and non-judgemental listening enabled CYP to express distress safely, paving the way for emotional regulation and improved communication within families.
2. Second, practical, co-produced tools, such as grounding strategies, sensory adjustments, and negotiated plans with schools, translated listening into action, embedding coping mechanisms that families could sustain beyond the intervention period.
3. Third, behavioural and identity-level change was evident: young people described moving from avoidance and crisis management to renewed participation, confidence, and future orientation.

The case studies also demonstrate the importance of context and continuity in shaping outcomes. For some families, progress was accelerated by coordinated school support or new peer environments; for others, ongoing external pressures limited the pace of improvement despite relational gains. This diversity underscores the LINK service's strength as a flexible and adaptive model that can accommodate complexity rather than prescribe uniform pathways.

In evaluative terms, these narratives provide qualitative evidence of impact and sustainability, illustrating how short-term relational work can catalyse enduring change when embedded in the child's everyday ecology. They reaffirm the central learning from this evaluation: that early, relationship-based, and contextually attuned support not only prevents escalation but fosters genuine transformation in children's and families' capacity to manage challenges and maintain wellbeing over time.

Summary of Question 1: What impact is the LINK service creating and how?

This section has drawn together evidence from multiple strands of the evaluation to address the question: **"What impact is the LINK service creating and how?"** It has explored how the LINK service's model delivers early, relational, and contextually attuned support that strengthens wellbeing and resilience for children, young people, and families. Drawing on qualitative interviews, sub-questions examined how the

service operates as a preventative early-help offer, the mechanisms through which change occurs, and how these improvements are sustained over time. The section also presented the coordination-only strand of the LINK service and a series of longitudinal case studies that illustrate individual journeys in depth. Together, these strands provide a comprehensive picture of impact: demonstrating that the LINK service enables meaningful emotional, behavioural, and relational change while building stability and confidence across home, school, and community contexts.

To answer question one, the LINK service is creating clear and sustained positive impact for children, young people, and their families. The mechanism of impact combines relational consistency, practical skill-building, and system navigation to prevent escalation and restore everyday functioning. The service supports children to regulate emotions, rebuild confidence, and re-engage with school and social life, while enabling parents to regain stability and hope. By bridging gaps between education, health, and social care systems, the LINK service provides a dependable early-help layer that strengthens both individual resilience and collective capacity within the local ecosystem.



Photo 9. CYP artistic expression of emotions

2. To What Extent is the LINK Service Being Implemented in Line with Plans and Stakeholder Expectations?

The Barnardo's LINK service was introduced in Cumbria as a response to growing recognition of a critical service gap: young people and families experiencing emerging social, emotional, and mental health needs who did not meet thresholds for specialist provision. Over the course of its implementation, the LINK service has developed from a small pilot in three Primary Care Networks (PCNs) into a service covering six PCNs. This section describes how the LINK service has been implemented in line with its original design and with stakeholder expectations, drawing on stakeholder accounts (largely staff, referrer, and board members). The following sections highlights the implementation of the service through themes: coordination and communication, referrals and accessibility, stakeholder involvement, flexibility and adaptability, and addressing local needs and context.

Coordination and Communication

From its inception, the LINK service was designed to offer a simple, consistent, and transparent process for handling referrals and communicating with both families and referring professionals. Fidelity to the original vision was described across multiple stakeholders within the data. Staff described the use of a centralised referral inbox, a weekly allocation meeting to review all new referrals, and a structured process that ensures no case is left in review for long periods. This operational “heartbeat” reflects precisely the intention of commissioners: to provide a dependable, routine mechanism for triage that could stand in contrast to the lengthy silences families often experienced elsewhere.

“We accept referrals from any professional. The bulk of those at the moment are GPs and schools but we do accept referrals from any professional... we hold weekly allocations meetings. So, a referral will be discussed, the maximum wait will be a week.” LINK service worker 1

In its first year, the LINK service focused on embedding these core coordination processes and establishing trust with early referrers. The regularity of allocation meetings and the clear referral pathway enabled GPs and schools to begin using the LINK service with confidence, relying on it as a predictable and dependable option rather than viewing it as an experimental offer.

By the second year, coordination and communication had become more sophisticated. Families and referrers began receiving confirmation emails acknowledging receipt of

referrals and providing a timeline for when cases would be discussed. This was not explicitly part of the original design but emerged in response to feedback and rapidly became one of the LINK service's most valued practices. Stakeholders describe this feature as creating reassurance, reducing uncertainty, and distinguishing the LINK service from other services where referrals often "disappeared" into the system.

"It sounds really strange but I really like getting the confirmation email to say we've got it, we'll sit on this date because I can put referrals into other services and you just don't hear anything from them until they're like, oh yeah we want to come and see this child and I'm like I didn't even know they'd been accepted to the service or anything like that, so knowing that they've got the referral, I can confirm with the parents that I've definitely put it in, this is the confirmation, this is the date they're going to discuss the referral on. And then I know within about 10 days from that date, if I haven't heard anything I know I can make contact. And it also helps the parents and the students as well having that confirmation and that date of when they're going to discuss it, so they've got a bit of a target and a timeline." LINK service referrer 1

By the third year, the LINK service's coordinating role had extended beyond its internal systems into the wider service ecology. Staff emphasise that they routinely redirect families to more appropriate services if the LINK service is not the right fit, ensuring children are not left unsupported. This represents strong fidelity to the original purpose of being a "bridge" service but also added value in the sense of preventing families from experiencing rejection without guidance.

"Yes, we're a coordinating service as well. We tend to do a lot of the coordination which is where we determine another service for them to go to." LINK service worker 2

Strategic stakeholders acknowledge that while the LINK service has met expectations around coordination and family-facing communication, the LINK service needs to be more visible across the sector. Within the first few years of implementation, local council partners in particular were perceived as less engaged, suggesting that further proactive promotion may help.

"I think it's a lack of promotion, I think it's lack of selling yourselves as well, if I'm being totally honest, to the council to be a supporting arm, to be a supporting mechanism." LINK service board member.

With greater efforts in communication, the LINK service was able to engage local councils and build relationships which ultimately led to a service contract.

In summary, over three years the LINK service has moved from establishing reliable internal processes, to developing family-facing communication practices that add clear

value, to playing an outwardly coordinating role in the wider system. The LINK service has transitioned from a socially prescribed service – to a system that leads and initiates the social prescription to other services. Fidelity to the original design has been consistent, and added value has been created through enhanced transparency and relational reassurance for professionals and families alike.

Referrals and Accessibility

The LINK referral system was intended to be simple, at a low-threshold, and primarily routed through GPs and schools. This aim has been consistently achieved, and staff describe the use of a single form, sent to a shared inbox, which is then discussed at the weekly allocations meeting. This ensures equitable and timely consideration of cases.

“So, referral process is we have a referral form that's completed by the referrer and sent into our email address... We accept referrals from any professional. The bulk of those at the moment are GPs and schools... we hold weekly allocations meetings... The majority will go on for an assessment... I would estimate within four weeks someone will be contacted for an assessment.” LINK service worker 3

In its first year, the process was swiftly and consistently established, signalling a strong commitment to the model. This stood in stark contrast to CAMHS, where families often experienced long delays before even receiving an initial response. Early referrers quickly recognised the LINK service as a reliable and timely option for addressing lower-level need.

By the second year, rising demand began to create pressures. Waiting times extended, with some families waiting between three and six months for ongoing work. However, the LINK service remained faithful to its design by maintaining flexible interventions, refusing to impose a rigid “six-session” cap that might have shortened waits at the expense of meaningful engagement. Staff describe this balance candidly: waits were sometimes long, but fidelity to the principle of flexibility for the child was prioritised.

“The wait times can vary really because we have a flexible approach, we're not a six-session service... I'd say on average it's maybe three to six months... and like I said now we've got two more practitioners in each area that has halved, now we've seen that that's halved which is really good.” LINK service manager 1

In the third year, adaptation occurred to strengthen accessibility. Recruitment of additional practitioners halved wait times in some localities, showing the service's capacity to scale while keeping fidelity to its core processes. Stakeholders, particularly

GPs, explicitly contrast the LINK service's accessibility with CAMHS, emphasising that assessments within weeks and one-to-one support within a couple of months made families feel engaged and valued.

"My waiting list to kind of first assessment... I think that was about a couple of weeks and then the wait until kind of 1 to one sessions... was about... six or seven weeks... I think the children, adolescents, mental health... it's about a year... So, the fact that they get that initial kind of assessment contact in a couple of weeks and then not too long afterwards... makes it feel they're being engaged with and valued." LINK service referrer 2

Accessibility has also been relational rather than purely procedural. Schools, in particular, describe the LINK service as their first port of call, emphasising the ability to speak informally with LINK service workers to judge appropriateness before submitting referrals. This informal accessibility was not specified in the original design but represents significant added value, creating a culture of approachability and responsiveness.

"LINK tends to be my first port of call for any sort of referral unless I think it's higher tariff... I've just emailed or rang [LINK service Worker] and had a chat with them about whether they think LINK's the right service... and then they either said yes or no or pass me on to a different service." LINK service referrer 3

Overall, the referral and accessibility systems have remained faithful to their original aims across three years, while also evolving to provide relational accessibility and to demonstrate visible improvements in wait times as capacity has grown. The added value has been substantial, especially in comparison to the long waits of alternative services.

Stakeholder Involvement

The LINK service's origins lie in a collaborative recognition of a significant service gap. Fidelity to this principle of stakeholder involvement is evident across the data. Board members, commissioners, GPs, and Barnardo's staff all recall the collective effort to design a service that would meet Cumbria's needs.

In its first year, stakeholder involvement was central. The steering group guided fundamental decisions such as age range and scope. For example, the decision to extend provision up to age 19 arose directly from stakeholder feedback about young people "aging out" of CAMHS before receiving help. This shows how the LINK service has led collaboration but also how the services have responded to people's needs.

“Can we do from the age of six to nineteen? And the reason why we chose nineteen was... If the kid turns seventeen and then the waiting list is over a year, they're rejecting them... we need to have something to bridge over that gap to take up to nineteen.” LINK service board member 2

During the second year, stakeholder involvement shifted from design to co-production in practice (clinical professionals provided input into the service). Staff describe the LINK service as moulding itself to Cumbria's needs, explicitly crediting the flexibility afforded by commissioners as enabling adaptation. This demonstrates how the LINK service has achieved the original plan's placing emphasis on local tailoring, while also representing added value in the depth of ownership stakeholders felt.

“So, it's been lovely to see the development of LINK mould to what Cumbria needs, social prescribing to be for Cumbria... it hasn't been a black and white contractor... that flexibility has been able to be the magic within LINK really.” LINK service worker 5

By the third year, stakeholder involvement was most visible in-service expansion. Originally launched in three PCNs, the LINK service expanded to six in response to commissioner demand. This scaling was not imposed but requested by stakeholders impressed with the outcomes, demonstrating that the LINK service's fidelity to collaborative principles had produced trust and momentum.

The added value of stakeholder involvement is evidence. Rather than passive oversight, stakeholders remain active shapers of the LINK service's evolution. This has created a deep sense of ownership and sustainability, ensuring the service is not seen as “Barnardo's programme” but as a collective local achievement.

Flexibility and Adaptability of the LINK Service.

Flexibility was embedded into the LINK service's design from the outset, with the intention that the service would not replicate rigid clinic-style models but would instead adapt to young people's needs. Fidelity to this principle is evident throughout and was reinforced by early delivery. Staff describe their practice as “authentic chameleons,” drawing on evidence-based approaches but tailoring delivery to each individual.

“We've got that flexibility to move and to meet that person where they are... I suppose that would be the biggest thing I would say with LINK, is I'll meet you where you are right now, where you need.” LINK service worker 6

In the first year, flexibility was most evident at the practice level, as practitioners responded to the varying readiness and needs of children. There was an absence of rigid protocols and there was no insistence on a fixed number of sessions, and practitioners could alter the pace and style of interventions.

By the second year, flexibility became more structural. Staff openly acknowledged that some young people required more intensive support, while others could benefit from shorter interventions. This was managed within existing capacity, demonstrating adaptability without abandoning the original ambitions of the LINK service.

“Every young person we meet is in a different place and needs something different and we work with that... it talks about being an authentic chameleon and you have to wear different hats for different young people.” LINK service worker 7

The third year highlighted the LINK service’s adaptability at an organisational level. Rapid scaling risked drift from the service’s ethos, so managers intervened decisively with strengthened supervision and clear behaviour frameworks. This represents fidelity to the service’s values, ensuring that growth did not compromise integrity.

Stakeholders consistently highlight Barnardo’s third-sector agility as an added value. The ability to listen, adapt, and make changes in response to feedback from schools, young people, and commissioners is described as a core strength.

“...that’s the beauty of working with third sector organisations, that they are flexible... and they listened to what the kids were saying as well.” LINK service boards member 1

Over the past three years, flexibility has remained a defining feature of the LINK service, indicating a service that has remained adaptable to population needs, not only at the level of individual practice but also at the level of organisational culture and system-wide collaboration.

Addressing Local Needs and Context

A distinctive feature of the LINK service’s implementation is its attention to Cumbria’s geography and local context. The LINK service ambition to tailor provision to local needs has been realised. Staff describe working across dispersed rural areas, navigating isolation and transport barriers, and adapting their delivery to suit the realities of local communities.

“I’ll see young people up to half an hour away in little villages, and it’s isolation... our managers and our service being so flexible I don’t feel that there are loads of barriers really.” LINK service worker 3

In the first year, the LINK service's focus was on establishing provision in its initial PCN areas, providing visible support where previously there had been little. Fidelity was expressed through embedding quickly and visibly in local schools and GP practices.

By the second year, patterns of demand began to diverge between areas. Staff describe Eden as generating large numbers of referrals, while Keswick and Solway initially had fewer but equally pressing needs. The LINK service responded by sharing caseloads across boundaries, showing fidelity to the principle of equity while adding value by ensuring no area was left unsupported.

By the third year, strategic attention turned to expansion into historically under-served areas. Stakeholders describe Keswick and Solway in particular as "forgotten" communities, where rurality and perceived affluence had masked unmet needs. The LINK service's expansion into these areas demonstrates fidelity to the plan of addressing service gaps, while creating added value by correcting long-standing inequities.

"It really was really lacking in any service delivery [Solway]. Mainly because of its rurality." LINK service board member 2

More broadly, staff articulated how the LINK service has moulded SP into a uniquely Cumbrian model, adapting the concept for CYP in a rural context. Adherence to local tailoring is evident, and the added value lies in pioneering a new way of delivering support that feels embedded in local communities rather than imposed from outside.

"It's been lovely to see the development of LINK mould to what Cumbria needs." LINK service worker 4

Thus, over three years, the LINK service has demonstrated its commitment to local context: from filling immediate gaps, to balancing uneven demand, to expanding into forgotten areas and creating a truly localised model of youth SP.

Summary of Service Implementation and Fidelity to Design

Across three years of delivery, the Barnardo's LINK service has grown alongside the community and provided consistent and tailored support. Hence, the LINK service has consistently demonstrated fidelity to its original design while also generating clear added value which is evident through:

- The establishment of a predictable coordination processes through weekly allocations.
- Maintenance of simple referral routes and offering timely assessments.
- The involvement of stakeholders in the co-design and expansion of the LINK service.
- The delivery of a flexible, evidence-based, child-centred service.
- The flexibility to tailor provision to Cumbria's unique geography and context.

The data indicates that the LINK service has exceeded expectations in several ways: providing transparent and reassuring communication beyond what was originally planned; offering relational accessibility that has made schools and GPs view it as a first port of call; and addressing historically forgotten areas with little or no provision. Stakeholders consistently describe the LINK service as not just meeting but surpassing its intended role, filling vital service gaps, and creating trust across sectors. It has become a cornerstone of early intervention provision in Cumbria, characterised by coordination, accessibility, flexibility, and deep alignment with local needs. The LINK service has transitioned from a socially prescribed intervention, into an embedded social prescribing system that refers outwards within the integrated sector.

What is the Perceived Level of Integration into Existing Systems?



Figure 26. Integration into systems

Analysis of the data sets highlighted how the LINK service became embedded within wider health and community systems through its relational approach, which was foundational to its sustainability. As illustrated in Figure 26, integration occurred not through structural alignment alone but through strong, trusting relationships with schools, GPs, families, community organisations, and specialist services. These connections formed the bedrock upon which trust, engagement, and impact were built. Referrers, particularly school staff, emphasised that consistency in staffing meant young people were not repeatedly re-explaining their circumstances to different professionals but instead benefited from a sense of continuity. This stability in relational contact was viewed as a direct enabler of care that felt coherent and dependable over time.

“The workers that we have, we’ve been designated certain workers, so we have that continuity of care for that young person.” LINK service referrer 6

This sense of sustained relational presence was echoed by parents, who consistently valued the role of LINK service workers in bridging the often-fraught gap between families and schools. Parents described feelings of isolation and uncertainty prior to the LINK service's involvement, suggesting that relationships with LINK service workers did not simply provide practical support but carried emotional weight, easing feelings of abandonment within complex systems.

"We felt alone in all areas. We didn't know where to go to regarding school - all the help that we're getting from [LINK service worker] in between, at least at the end of that, if we've got a diagnosis - look where we've come with the help from [LINK service worker] in that area." Parent 1

CYP's accounts echoed this perspective by highlighting that relational trust was a precondition for openness. For CYP, the qualities of friendliness, calmness, and positivity were essential to their willingness to disclose vulnerabilities. The LINK service worker's presence was described as having the ability to disarm fear which helped to create emotional safety and influenced dialogue about difficult feelings and experiences.

"She's just got a very friendly presence about her, and it makes me feel easier to discuss my problems and my highs and lows because she'll sit there and remain calm and positive with me." Young person 4, age 15

Staff also highlighted how the structure and operationalisation of the service enabled greater relational depth. For example, they described how unhurried time, outside of clinical constraints, allowed for genuine care to be demonstrated. The LINK service created the conditions where relationships could thrive, because staff were not pressured into transactional encounters.

Commissioners also framed the LINK service as exemplary because of the relational trust embedded in its service delivery model. Commissioners described the LINK service as "a shining example of integrated care" highlighted that integration here was less about structural arrangements and more about relationships that spanned professional and organisational boundaries. The emphasis on partnership between Barnardo's and PCNs, built on trust and shared risk, further underlined that sustainability depended on collaboration that was relational rather than transactional.

There were some challenges highlighted, for example, referrers raised frustrations about siloed working, particularly when GP referrals bypassed schools. This breakdown in communication fractured integration and created gaps in shared understanding.

“It’s harder when the GP refers some of our students because I don’t get that information.” School staff referrer 2

Concerns about integration were also linked to area-based variation in access, with referrers and system partners describing differences in availability depending on locality and Primary Care Network coverage. This meant that children attending the same school could have different access to the LINK service based on where and how they were registered, contributing to inequitable access across areas. As one GP explained:

“You might have children from the same school who may or may not have access to it depending on which GP practise they register to.” LINK service referrer 4

This uneven access was also acknowledged at a strategic level within the LINK service itself, with senior staff recognising the risk of geographical inconsistency in provision:

“My hope and aspirations for the future is that the LINK service is not a postcode lottery, it is across all.” LINK service worker 10

Commissioners highlighted barriers, such as referral thresholds influenced by systemic pressures. For example, long waits for CAMHS and frustration with statutory services may have resulted in inappropriate referrals to the LINK service. These challenges meant that the relational depth was jeopardised through forcing the LINK service being positioned to manage needs beyond its remit.

“Communication back to GPs, particularly, and the schools to help them to understand that the LINK Service is not a holding service for CAMHS. If the appropriate referral is to CAMHS, then that’s where the referral should go to. And that our LINK service workers don’t have the responsibility of dealing with a child or young person with suicidal thoughts, for example.” Clinical director 1

Summary of the Perceived Level of Integration within Existing Systems

The data demonstrates that integration within the LINK service is achieved primarily through relationships across the sector and with CYP and families. Hence, trusting, consistent connections between LINK service workers, families, schools, and health professionals formed the foundation of effective collaboration and were central to the service’s perceived success. The LINK service’s ability to maintain relational continuity and create emotionally safe spaces for children and parents enabled smoother communication across systems and reduced fragmentation in care. Sustaining and strengthening integration will therefore depend on protecting relational continuity while

addressing the structural and procedural barriers that limit equity across the wider system.

Summary of Question 2: To what extent is the LINK service being implemented in line with plans and stakeholder expectations?

This section has drawn together evidence from stakeholder interviews and documentary sources to address the question: **“To what extent is the LINK service being implemented in line with plans and stakeholder expectations?”** It has explored how the service has developed from its initial pilot phase to a county-wide model, maintaining fidelity to its original design while adapting to local context and emerging needs. The analysis examined five core implementation themes: coordination and communication, referrals and accessibility, stakeholder involvement, flexibility and adaptability, and the service’s responsiveness to Cumbria’s geography and local priorities. Together, these themes show how the LINK service has evolved while preserving the central principles of accessibility, collaboration, and child-centred practice that underpinned its inception.

To answer question two, the LINK service has demonstrated strong fidelity to its original vision. It has established robust and transparent referral and coordination systems, embedded clear communication with families and partners, and maintained flexible, evidence-informed delivery. Stakeholders consistently describe the service as collaborative, responsive, and integral to local provision. Importantly, implementation has not only met expectations but generated clear added value, through transparent family-facing communication, relational accessibility for referrers, and expansion into previously underserved areas. The result is a well-integrated, trusted, and adaptable service that exemplifies effective early-intervention delivery in a complex local system.

3. What Enablers and Barriers Affect the Sustainability of the LINK Service and How?

This section explores the factors that support or threaten the long-term sustainability of the LINK service. The analysis brings together perspectives from staff, referrers, parents, CYP, and commissioners. Key enablers include the strength of relationships with families and professionals, the flexibility and holistic nature of the model, and clear evidence of positive impact. Barriers focus on funding insecurity, workforce capacity pressures, communication gaps, and systemic inconsistencies. Figure 27 highlights these at a glance, followed by detailed evidence and explanation.

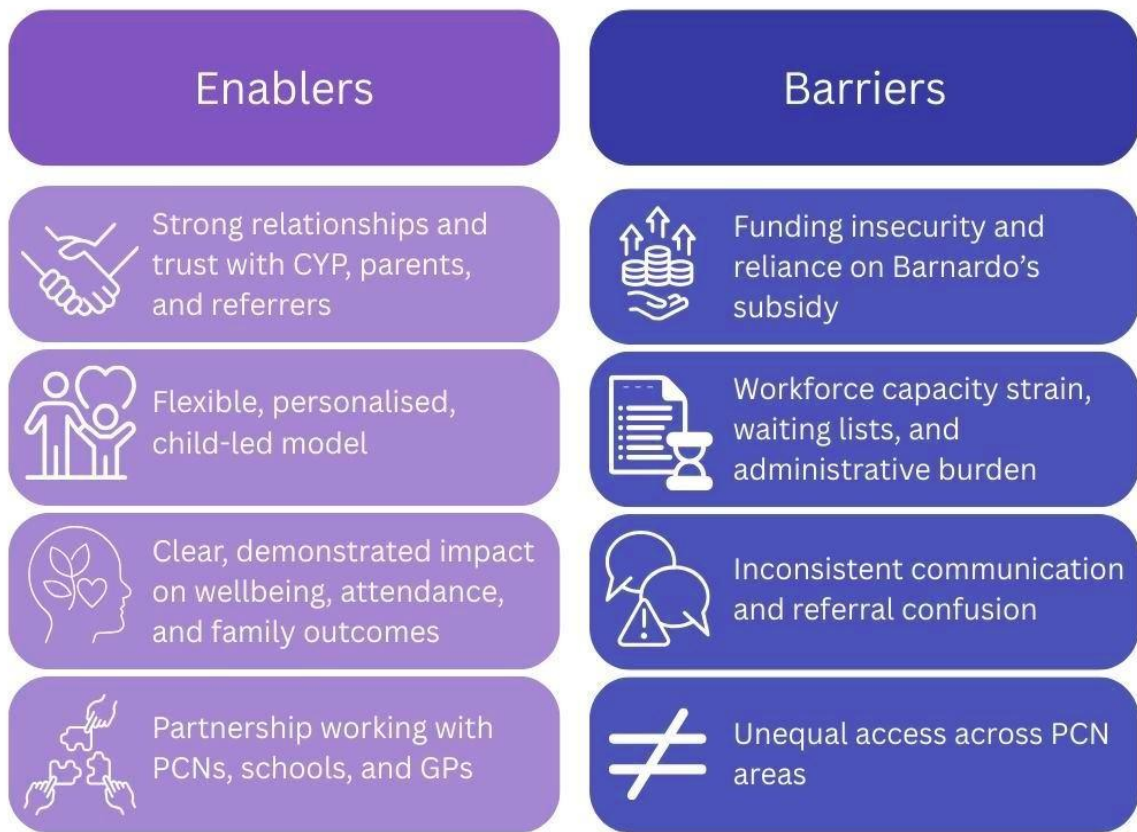


Figure 27. Barriers and enablers to sustainability of the service

Key Barriers to Sustainability

Workforce Capacity and Administrative Burden

LINK service workers spoke to the dual role of capacity and resources as both an enabler and a major vulnerability. Staff consistently highlighted the adaptability of the model as central to its sustainability. Flexibility was not just an operational strength but a philosophical one, allowing interventions to be shaped around young people's lives rather than requiring CYP to adapt to rigid structures.

“Every session is led by the young person. It’s their session, it’s for them and we’re working for them.” LINK service worker 11

Parents further illuminated this by describing LINK service workers as transformative figures whose commitment and kindness extended beyond expectation. For families, this personal dedication translated into experiences of feeling valued and cared for, which contributed directly to their perception of the LINK service as sustainable.

“She’s probably gone above and beyond what she needs to do.”
Parent 8

CYP expressed similar sentiments, articulating the empowering quality of being able to shape their sessions. Choice and autonomy were central to how they understood sustainability, with ownership over the process strengthening engagement and motivation.

“It’s definitely led by you and what you want to do.” Young person 3,
age 10

Commissioners reinforced this view by positioning LINK service workers as uniquely placed to support complex family needs, often more effectively than GPs. They praised Barnardo’s commitment to training, governance, and supervision, framing this as a depth of investment not achievable within primary care. Such organisational infrastructure was seen as vital to sustaining quality, accountability, and staff wellbeing.

However, whilst capacity was simultaneously described as the greatest threat to sustainability, staff also suggested that funding insecurity is a persistent and destabilising issue. The data illustrated the practical anxieties about financial continuity and broader fears about the viability of scaling the service.

“For me the biggest challenge for Barnardo’s is how we scale this up in a way that’s cost-effective to a charity.” LINK service worker 10

LINK service workers also described how the service had become “administration heavy,” with shortages compounding strain. Referrers illustrated the consequences of these delays, explaining how six or seven weeks between referral and first contact often led to disengagement, as the young person’s circumstances had shifted.

Parents raised additional concerns around variability in quality and questioned whether six to twelve weeks was sufficient to make meaningful change.

“There can be a bit of an inconsistency between workers in how things are delivered.” Parent 1

CYP pointed to practical barriers such as scheduling and accessibility, which shaped their ability to engage fully.

Funding Insecurity

Commissioners made explicit that existing funding streams were insufficient, particularly for governance and leadership roles. Their accounts illustrated how the

sustainability of the LINK service relied not only on Barnardo's subsidy but also on systemic gaps in commissioning frameworks.

“That doesn't provide for sufficient funding to also employ the other roles that are necessary to govern the service, to manage and lead the service.” Clinical manager 1

The Clinical Director described this shortfall as “the biggest threat to its future,” while commissioners more broadly emphasised the need for clearer long-term financial planning and integration with ICSs. Sustainability, they argued, depended on positioning the LINK service as complementary to statutory provision rather than a substitute for underfunded services.

Inconsistent Clarity and Communication

Some families highlighted gaps in clarity around the service which created challenges. Parents described feelings of exclusion when communication bypassed them and was directed only to the child. However, this was not a universal experience; other families described communication as clear, inclusive, and appropriately balanced between the child and parent, suggesting that experiences of family-centred communication were inconsistent rather than uniformly problematic. It is important to note that the service is primarily a children and young people-focused intervention rather than a family service, and that confidentiality and consent considerations necessarily shape how information can be shared with parents. Such accounts suggest that sustainability depends not only on communication taking place, but on how expectations around inclusion, boundaries, and confidentiality are clearly communicated and negotiated with families.

“If you had maybe one that was only talking to the child and turning up and doing the sessions, then you felt you're out of the loop.” Parent 2

Parents also called for clearer explanations of safeguarding processes; while no concerns were raised about the safety of practice itself, uncertainty about how safeguarding procedures operated contributed to anxiety for some parents. Staff reflected on their own difficulties in articulating the LINK service's coordination role. The challenge of explaining processes whose outcomes were uncertain underscored the complexity of the LINK service's remit and the difficulties of communicating this complexity clearly to users.

“When you explain things to a LINK user like a coordination or an assessment, it's quite hard to explain fully what that means because as well we don't know what the outcome is going to be so.” LINK service manager 1

CYP described nervousness prior to engagement, revealing how uncertainty about what to expect could manifest as anxiety and self-doubt.

“I was nervous, the entire morning I was like ‘Oh my god, what if she hates me?’” Young person 5, age 12

Commissioners acknowledged that such challenges reflected broader systemic confusion. They noted that referrers themselves often struggled to keep track of changing pathways, while schools sometimes misunderstood the LINK service’s remit, leading to unrealistic expectations around issues like persistent non-attendance. These misunderstandings suggested that clarity was not simply about individual interactions but about embedding a shared understanding of the LINK service’s purpose across systems.

Key Enablers to Sustainability

Demonstrable Impact

One of the enablers (see Figure 27) centred on the impact and added value of the LINK service, which participants across groups consistently described as transformative. For referrers, the evidence of improved attendance and emotional regulation provided visible indicators of success, reinforcing their confidence in the model.

Parents described changes in deeply personal and profound terms, capturing the lifesaving and restorative dimensions of the service. Their accounts illustrated how the LINK service did more than provide short-term support: it created the conditions for recovery, communication, and renewed family connection.

“He went from being really unwell and no longer wanting to be here to having these sessions and then being able to speak to us, smiling again.” Parent 4

CYP themselves described the service as transformative, helping them to recover their sense of self and vitality.

*“It helped me get back to normal and it helped me get my spark back”
Young person 3, age 10.*

Staff emphasised the preventative dimension of these outcomes, positioning early intervention as key to reducing long-term risks. Their accounts framed the LINK service not just as a response to crisis but as an investment in prevention.

Strong Relationships

Across all participant groups, the strength and quality of relationships emerged as the defining feature of the LINK service model. Children, parents, and referrers consistently described how trust, empathy, and continuity of care underpinned the service's impact. LINK service workers were praised for their calm, friendly approach, and ability to listen without judgement, helping young people rebuild confidence and self-worth.

"She's just got a very friendly presence about her... it makes me feel easier to discuss my problems and my highs and lows." Young person 4, age 15

Parents described these relationships as life-changing, providing stability and hope during difficult times. LINK service workers were seen as compassionate professionals who went "above and beyond," fostering both recovery and renewed family connection.

"She used to sometimes ring me, and I'd just burst into tears, and she would sit for an hour on the phone until I'd calmed down." Parent 1

Referrers also highlighted strong, collaborative relationships with LINK service worker, describing them as reliable, approachable, and responsive partners.

"We've just got a really good rapport with all of them... we know exactly where we are with them." School referrer 1

Collectively, these accounts show that the LINK service's success is rooted not in process or structure alone but in the relational depth between workers, families, and partners. Protecting this ethos of trust, compassion, and connection will be vital to sustaining the service's distinctive impact.

Partnership working

A recurring thread across stakeholders was the notion of partnership not as a static arrangement but as a dynamic, evolving relationship built on reciprocity and shared purpose. The service is described as functioning effectively precisely because it transcends organisational silos: rather than existing within the confines of a single agency, it is sustained through a constellation of partners including, local authorities, integrated care communities, GP practices, and NHS providers:

"I do think it works well as a partnership, not just from the NHS. I think it works well as a partnership where you've got the local authority, you've got the integrated care communities, you've got the GP practices, you've got everybody coming together to support that service." Local authority director

“In the early days we did this and now our organisation wants to do that, so you need to fit with us. And of course, they have to grow, and they have to make changes, but that has always been done with us in mind. And, you know, the recruitment is still done with us in mind and all of that. So, I think that is the difference that I’ve seen. That would be the USP for me that it’s a true partnership approach.” LINK service board member.

These organisations collaborate around a common goal of supporting families and communities. This collaborative configuration is not merely structural; it represented a deliberate alignment of intentions and responsibilities that allows the service to operate as a genuinely integrated system of support.

Personalised Child-led Model

Commissioners reinforced these accounts by positioning the LINK service’s flexibility and cross-setting model as its distinctive strength, particularly against the backdrop of long CAMHS waits. They highlighted the contrast between the LINK service’s child led approach and rigid NHS timeframes, describing the supportive flexibility of the LINK service as essential to its success.

“Supportive flexibility that allows that child or young person to move on when they’re ready rather than a hard line, ‘six weeks and you’re out.’” LINK service commissioner 1

Beyond measurable outcomes, referrers and staff also spoke of the LINK service as a source of hope. This symbolic dimension suggested that the LINK service was valued not only for what it did, but for what it represented, a commitment to children and families in systems where hope was often scarce.

“Barnardo’s LINK gives people hope, and it certainly gives me hope.”
LINK service referrer 9

While few barriers were raised under this theme, commissioners did warn of the risk that the LINK service’s unique features could be eroded under pressure to expand or focus narrowly on throughput.

Summary of Enablers and Barriers to Service Sustainability

Taken together, the perspectives of staff, referrers, parents, CYP, and commissioners suggest that the sustainability of the LINK service rests on a balance between its relational strengths (e.g., personalised, child led model) and systemic vulnerabilities (e.g., funding insecurities). Its holistic, preventative, and child-centred model is widely

seen as transformative, producing tangible outcomes for children and families while relieving pressure on schools and GPs. This impact is the programme's strongest enabler, giving Barnardo's a compelling case for long-term investment. However, sustainability could be undermined if funding insecurity, workforce capacity, referral confusion, and systemic inconsistencies are not addressed. Commissioners in particular stressed the need to secure resource for governance and training, while also resisting pressures to dilute the model for the sake of throughput. Importantly, the evidence is clear that GP practices and schools do not have the capacity to provide this support alone. The LINK service fills a critical gap by offering the relational time, system navigation, and emotional support that referrers cannot deliver within existing constraints. Protecting these core features while addressing funding and capacity pressures will be essential for ensuring that the service's distinctive value is sustained and scaled within wider systems of support.

What Enabling Factors are Needed for the LINK Service to be Successful?

The findings of the evaluation highlighted that staff perceived a positive culture around supervision and training. However, they acknowledged clear gaps and future workforce development needs. Two overarching themes were evident: (1) the central role of Barnardo's in providing training, supervision, and governance; and (2) the need for more formalised, role-specific training, systems competence, and structured career-progression opportunities.

Staff consistently highlighted how Barnardo's provided essential training, supervision, and governance that primary care could not otherwise sustain. This was viewed as key to the safety and quality of the LINK service:

"From a PCN point of view, I know that Barnardo's are taking care of the training, day-to-day supervision and governance and I'm not having to scramble around and find GPs to supervise LINK service workers and that the GP wouldn't be the right person to provide that supervision either. We need somebody with the skills and experience that Barnardo's bring, to supervise this service and to provide the governance structure for it. We, in primary care, don't have the resources, skills or experience to provide what Barnardo's bring to this and that for me is the real value in it all." Barnardo's board member 2

Supervision was described as case-focused with additional space for holistic person-centred support. LINK service workers valued the opportunity to bring "their whole self" to supervision, which was perceived as vital to sustaining their ability to work relationally with young people:

"So we have four to six weekly supervisions with our line managers, so in that time we have personal supervision for us where I can talk about how I am, and that's my whole self, it can be what's going on at home, family, that is anything it needs to be, which is really good because I think we're all encouraged to just bring our whole self to work because if we don't how can we be there for the young people, if that makes sense, if we're not getting support, so we have that, and then the other half of it is case supervision, so we discuss through every case that we have, whether it's just an offload or it's getting a bit of advice and forward planning for what the support's going to look like, we have that." LINK service worker 4

Staff also highlighted other training, not currently provided, that they felt was important for future development. In addition to safeguarding, trauma, and equality and diversity training provided by Barnardo's, they felt that bespoke training specifically for social prescribing with children and young people would be beneficial, though, as this is an emerging area, there is limited existing training provision. LINK service workers often

relied on ad-hoc webinars, and some reported managing complex and lengthy cases without a clear training framework:

“I have done a lot of training since I’ve started, and I suppose it’s more understanding the trauma training, child exploitation training, you never know what’s going to come in on a referral. The equality, diversity, inclusion training, there’s been no specific social prescribing training as such.” LINK service worker 5

Staff also described some of the challenges with getting to grips with systems and data input. Staff perceived outcome entry and navigating IAPTUS as time-consuming and daunting, particularly for new LINK service workers who may have never used these systems prior to their role with Barnardo’s.

“I think for me, the side that I struggled with a little bit more, was getting my head around IAPTUS.” LINK service worker 6

Data analysis of the LINK service workers interviews suggested that staff preferred to spend time focusing on contact time with CYP rather than have time eroded by data input and administrative tasks. However, staff acknowledged that these systems were an essential part of the job but highlighted that IAPTUS training at induction, shadowing a senior colleague, recording templates, and protected admin time would be beneficial moving forward.

Staff also highlighted challenges in recruitment, particularly the lack of consistency in applicants’ qualifications or prior training. This was described as reflecting the wider context in which social prescribing for children and young people remains an emerging field, with no established qualification pathways, competency frameworks, or widely available role-specific training at the point of recruitment. As a result, it was not possible to recruit against a fixed set of social prescribing-specific criteria, and relational qualities and relevant lived or professional experience were therefore prioritised.

Importantly, staff emphasised that once in post, LINK service workers were well supported through Barnardo’s existing structures, including a structured induction, extensive safeguarding, trauma-informed and equality and diversity training, protected learning time, and opportunities for shadowing and ongoing supervision. Variations were therefore understood not as differences in workforce quality, but as differences in starting points and backgrounds within a developing role. These accounts highlight the importance of continued investment in role-specific training development, clearer progression pathways, and shared competency expectations as the service scales, particularly in the context of a national and sector-wide lack of established training frameworks for children and young people’s social prescribing. Without this wider infrastructure, there is a risk that the relational strengths of the LINK service become harder to sustain consistently as delivery expands.

These findings point to several workforce development priorities that can strengthen the LINK service moving forward. The following recommendations outline practical actions to address these gaps.

Summary of Workforce Development Enablers

The findings highlight that Barnardo's provides a strong foundation of supervision, training, and governance that underpins the quality and safety of the LINK service. Staff described supervision as reflective and supportive, enabling them to sustain the relational approach central to the LINK service's success. However, gaps remain in formalised, role-specific training, data and systems competence, and career progression pathways. Addressing these areas through structured induction, protected learning time, and clearer progression routes will be key to maintaining workforce confidence and preserving the service's relational integrity as it expands.

Summary of Question 3: What enablers and barriers affect the sustainability of the LINK service and how?

This section has brought together evidence from staff, referrers, commissioners, children, young people, and parents to address the question: “**What enablers and barriers affect the sustainability of the LINK service and how?**” It has explored the factors that support or threaten the service’s long-term stability, drawing on perspectives from across the delivery system. Sub-sections examined the key barriers to sustainability, including workforce capacity pressures, administrative burden, funding insecurity, and variability in communication and role clarity. These were balanced against the core enablers that underpin the LINK service’s strength: strong and trusting relationships with families and partners, demonstrable impact and positive outcomes, a flexible and child-led model, and a culture of partnership working that spans organisational boundaries. The section also considered workforce development as a central determinant of sustainability, highlighting the importance of supervision, governance, and ongoing training.

To answer question three, the sustainability of the LINK service is underpinned by the relational integrity of its model and the demonstrable value it brings to families and systems. However, long-term stability will require structural investment in funding, workforce development, and cross-sector alignment to ensure that these relational and preventative strengths are protected as the service continues to grow and evolve.

Limitations of the evaluation findings

The evidence presented above offers a detailed picture of the LINK service’s effectiveness and sustainability as part of the SP ecosystem. However, as with all complex service evaluations, some limitations in data quality and completeness should be noted to contextualise the findings.

Demographics and data completeness

The evaluation was only able to analyse the demographic information and outcome data that were provided to us by the service. Similarly, participation in the qualitative elements of the evaluation was entirely voluntary, meaning it could include only those individuals who were willing and available to take part.

Data Quality and Availability

The evaluation drew upon a wide array of data sources, encompassing perspectives from stakeholders, CYP, families, referrers, LINK service workers, and members of the wider community. This diversity of qualitative input provided a rich and multilayered understanding of the LINK service’s impact across various sectors and levels of engagement.

One of the evaluation's aims was to integrate these qualitative insights with Child Outcome Rating Scale (CORS) data via the IAPTUS system. However, this proved difficult due to limitations in the national dataset, particularly around data quality and completeness. These challenges are not unique to Barnardo's; they reflect broader issues commonly encountered in evaluations of SP initiatives involving CYP. Constraints such as small sample sizes, lack of control groups, and limited statistical rigour often impede the ability to draw robust conclusions especially regarding economic impact.

The project faced similar limitations, with outcome data for beneficiaries remaining sparse. While CORS data does offer useful indications of service effects on CYP wellbeing and provides a helpful starting point, it lacks the granularity needed to assess mental health outcomes in depth. Additionally, final scores are frequently influenced by young people's awareness that their engagement with the service is ending, which can distort results.

Although CORS is a validated tool for assessing psychosocial functioning, its simplicity and reliance on self-reported measures can introduce bias and reduce accuracy. This makes it less effective for capturing the nuanced outcomes of SP interventions. As such, the findings should be interpreted with caution, aligning with calls made by Polley et al. (2023) for more rigorous, comprehensive, and standardised approaches to evaluating the economic impact of SP.

Future Directions

This section examines the factors that enable the LINK service to deliver high-quality, sustainable support for children, young people, and families. It synthesises perspectives from staff, referrers, and stakeholders to identify what makes the model work in practice, what gaps remain, and how the service can continue to evolve. The section concludes with recommendations, key learning points, limitations, and next steps for service improvement.

As this evaluation was conducted as part of an ongoing learning partnership, several of the issues identified in this section have already been actively addressed by Barnardo's over the course of delivery. The LINK service evolved across the three-year evaluation period through continuous feedback loops, reflective dialogue, and collaborative sense-making between the evaluation team and service leads. As a result, some of the learning points and recommendations outlined below reflect practices that are already embedded and operating effectively within the service and are included here to evidence their importance as core components of the model. Others identify areas where further consolidation, consistency, or scaling would strengthen sustainability and impact as the service continues to develop.

Key Learning Points

The evaluation highlights eight core learning points (Figure 28) that explain why the LINK service was impactful, what hindered greater success, and what should be prioritised in future implementation.



Figure 28. Key learning points from the evaluation

1. The Relational Approach is a Core Strength of the Service

A significant and influential mechanism underpinning success was the strong, trusting relationships between LINK service workers, young people, and families. The relational approach enabled children to feel safe, articulate emotions, and practise regulation. Parents emphasised the value of “being heard” and the consistency of the LINK service workers.

2. Flexibility in Delivery Increases Engagement and Access

The LINK service's ability to meet families at home, school, or in community spaces reduced barriers and encouraged engagement from young people who might otherwise avoid formal settings. This flexibility was repeatedly cited as enabling early engagement and preventing escalation. Scaling should preserve flexible delivery models, even though it is acknowledged that they require more staff capacity and resources.

3. Co-Produced Strategies Supports Lasting Impact

Young people reported ongoing use of grounding strategies, emotional regulation techniques, and co-created coping tools after the LINK service ended. These portable strategies translated into improved functioning at home and in school.

4. Systems Working Strengthens Impact

The LINK service acted as a bridge between families, schools, GPs, CAMHS, and other services. This coordination accelerated support, improved referral accuracy, and prevented children becoming "stuck" on waiting lists.

5. Strong Governance Enables Early Success

The LINK service benefitted from strong governance structures, steering groups, and Barnardo's third-sector agility. The service could adapt inclusion criteria and referral processes quickly when demand spiked, sustaining delivery despite pressure. Investment in governance, data management, and cross-system credibility should be prioritised for replication.

6. Funding Insecurity and Workforce Pressure Could Threaten Sustainability

Short-term funding cycles, limited resources for leadership, and potential caseload growth placed staff and service stability at a potential risk into the future. Administrative burden and recruitment challenges may also have an impact on sustainability as shorter term funding may limit capacity. Longer-term funding and workforce planning are essential to preserve quality and prevent burnout.

7. Geographic Inequalities Limited Reach

Rural families faced barriers to attending group activities due to travel distance and associated costs. While the LINK service was able to draw on the wider Barnardo's infrastructure to provide practical support in some cases, access to such support was not always sufficient to fully mitigate these barriers. As the service scales, targeted rural access strategies (e.g., transport support, use of local community hubs, or flexible delivery models) would strengthen equitable reach across regions and ensure existing support mechanisms are applied consistently.

8. Data Gaps Limited Evidence of Long-Term Impact

While qualitative accounts were strong and consistent, quantitative evidence was limited by incomplete IAPTUS data, including missing or inconsistently recorded outcome measures, and lack of longer-term tracking. Future implementation should strengthen outcome monitoring, for example through follow-up measures, clearer linkage with routinely collected school data (such as attendance or engagement indicators), and fidelity indicators, in order to demonstrate sustained impact and return on investment.

Next Steps for Service Improvements

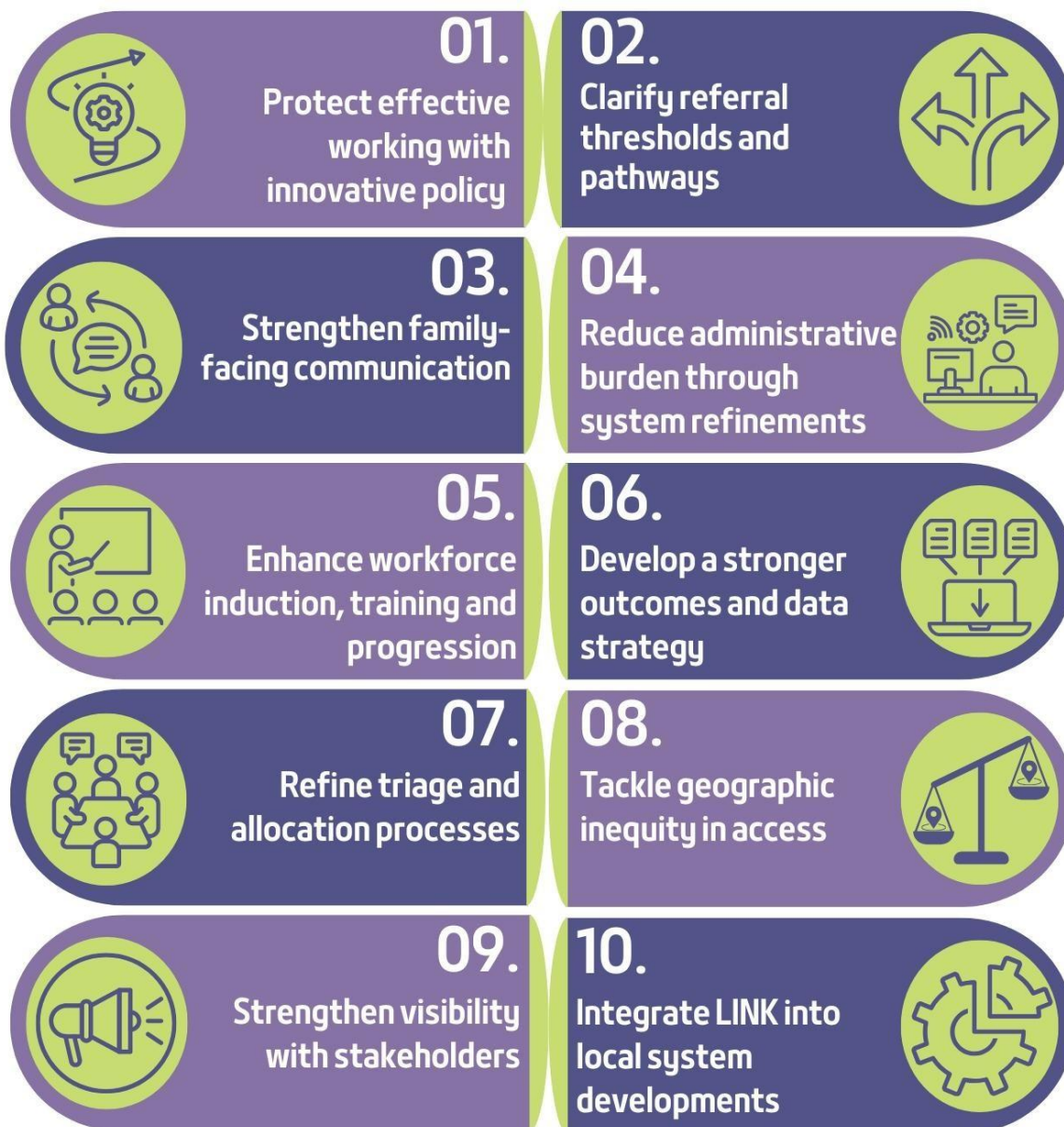


Figure 29. Key learning for service improvement

1. Protect effective working with innovative policy

The LINK service's effectiveness is rooted in consistent, relationship-based support. It is essential to safeguard small caseloads, continuity of a named LINK service worker, and regular supervision. Operational policies should cap caseloads and protect reflective supervision time from competing demands. This should be implemented in the near term to prevent dilution of the LINK service's core therapeutic mechanism.

2. Clarify referral thresholds and pathways

Provide referrers (GPs, schools, and others) with clear guidance on what the LINK service can and cannot accept, how referrals will be triaged, and examples of where alternative referrals will be signposted. An evidence-based protocol and accessible flowchart could be issued, ensuring consistency and reducing inappropriate referrals that occupy valuable capacity.

3. Strengthen family-facing communication

Building on the valued confirmation-email practice, the service could produce standardised “what to expect” materials for CYP and parents, including a child-friendly leaflet and detailed parent booklet. These should set out timelines, session structures, and likely next steps, particularly to reduce parent worries. These materials should emphasise the flexible and adaptability of the service as to not appear rigid when outlining the components of the intervention. In addition, practitioners should conduct a light-touch follow-up with families to help sustain momentum after they have concluded sessions with the service.

4. Reduce administrative burden through system refinements

Staff wellbeing and contact time with families can be preserved by streamlining data entry into IAPTUS, standardising templates, and protecting time for administration. LINK service workers new to the role could shadow experienced colleagues to build confidence with the system and learn how they can be more efficient with administration.

5. Enhance workforce induction, training and progression

To ensure staff efficiency and confidence in the role, the service could expand the induction process to motivational engagement techniques and advanced data systems training (e.g., IAPTUS). A clear role pathway, including accredited CPD and supervisory roles, should also be established to create stability and career progression opportunities. These opportunities may support staff retention and continuity for the service beneficiaries (a key part of its success).

6. Develop a stronger outcomes and data strategy

The LINK service should implement a standard data collection guide (for staff) and continue with consistent use of well recognised outcome measures (e.g., CORS). A follow-up protocol (at discharge, 3 and 6 months) could be introduced within the immediate term to evidence sustained impact following the conclusion of the service. In the longer term, the LINK service should explore linking outcome data with schools and PCNs to demonstrate broader impact beyond self-reporting measures.

7. Refine triage and allocation processes

The service should formalise a regular clinical triage meeting with explicit criteria, alongside targets for rapid first contact and a small-team response pathway for urgent

but below-CAMHS threshold cases. These refinements could be embedded in business as usual to manage demand effectively and reduce waiting times.

8. Tackle geographic inequity in access

Families in rural and under-served areas experienced barriers due to travel when attempting to attend group sessions and signposting services. To address this, the LINK service could consider transport vouchers or mobile delivery, and plan groups using deprivation and referral mapping. The service could actively refine new strategies to tackle geographic inequalities to ensure equitable access across the regions.

9. Strengthen visibility with stakeholders

To enhance the visibility of the service, the senior leadership of the LINK service could expand its promotion of the LINK service's remit and impact to councils, voluntary sector organisations, health services, PCNs and schools. Regular reporting packs that combine outcome data with case vignettes could be shared every 6 months to highlight the impact of the work.

10. Integrate the LINK service into local system developments

Over the longer term, the LINK service should align with Family Hubs and neighbourhood health structures to ensure it is embedded within early-help provision rather than operating as a time-limited pilot. This integration could reduce pressure on statutory services and strengthen sustainability, making a case that it should be a mainstay among services. In this sense, future models could maintain clear liaison functions with wider system partners and invest in coordination roles to ensure effective system navigation.

Summary of Service Improvement Priorities

Together, these 10 recommendations reflect the totality of evaluation activity across the three years, providing a practical roadmap for the LINK service's future development (see figure 29). They emphasise the need for immediate protections to relational practice and administrative systems, medium-term consolidation of workforce and data infrastructure, and longer-term sustainability through integration, equity measures, and demonstrable return on investment. By acting on these priorities within the suggested timelines, the LINK service could maximise its impact for CYP, families, referrers, staff, and stakeholders while ensuring a strong case for continued funding.

Service Improvements and The Learning Partnership

The learning-partnership approach was grounded in a collaborative ethos, in which the evaluation team worked closely with Barnardo's to co-produce knowledge, reflect on emerging insights, and iteratively refine practice. By integrating evaluative expertise with Barnardo's operational understanding, the team ensured that the evaluation remained both contextually meaningful and practically actionable, directly informing ongoing service improvement. This dynamic way of working enhanced the real-world relevance of the evaluation and supported its potential for wider scale-up. Consequently, the LINK service developed in parallel with the evaluation process. The accompanying table below illustrates this trajectory of growth and demonstrates how the evaluation recommendations were implemented by the LINK service team, enabling Barnardo's to translate the findings into practical improvements (see table 1).

Table 1. Service improvements from key learning.

Learning point from the evaluation activity	Service improvement made
Protecting low caseloads to ensure the sustained quality of deliver.	Ongoing monitoring and protection of caseload allocation ensuring a reasonably low caseload for each LINK service worker.
Clarify referral thresholds	Developed a robust triage and no closed-door process within the service which enhanced initial CYP assessments.
Enhance staff training and skills	Established a learning platform in which a range of training and shadowing opportunities were provided. These training opportunities included trauma-informed practice, safeguarding, and key principles of the CSSO framework. Staff were also allocated protected learning time to upskill.
Streamlining data entry	The service has invested in resources such as the IAPTUS handbook and a SharePoint which specifically outlines ways to improve efficiency in data entry. The service has adopted standardised data entry templates which can be imported directly into IAPTUS.
Strengthen visibility with wider system stakeholders	The service has actively promoted its offer to wider systems by meeting with key decision makers in several sectors (e.g., education). This was particularly successful with local authority as efforts to build relationships with decision makers led to a service contract.
Tackle geographic inequalities	The LINK service made efforts to tackle rural inequalities by offering group sessions in under-served areas (e.g., rural location of Talkin Tarn Country Park). Further efforts to tackle inequalities are ongoing.

Conclusion

The evaluation demonstrated that the Barnardo's LINK service delivered a distinctive and valued model of early, relational support for children, young people, and families as part of a social prescription from health or education providers. The strength of the LINK service was underpinned by a combination of skilled, reflective practitioners, strong governance, and deep community integration. The LINK service model aligned with national priorities outlined in the NHS *Fit for the Future* Ten-Year Plan and the Government's Family Hubs and Young Futures Hubs initiatives, which all emphasise integrated, community-based support for children and families. The findings therefore provide commissioners with timely evidence of how relational, non-clinical interventions can deliver on these strategic goals while addressing local need and reducing system pressure. However, sustaining the impact of the service will depend on continued investment in workforce development, data systems, and equitable access across regions. By protecting these core elements while embedding the LINK service within wider integrated system structures, LINK is well positioned to continue improving outcomes for CYP and reduce pressure on statutory provision.

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